FORM TO BE USED BY PRISONERS IN FILING A COMPLAINT UNDER THE CIVIL RIGHTS ACT, 42 U.S.C. § 1983

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS
_____ DIVISION

CASE NO. _____ 5:07CV00231 JMM/GTR

I. Parties

In item A below, place your full name in the first blank and place your present address in the second blank. Do the same for additional plaintiffs, if any.

A. Name of plaintiff: David Felty
ADC # 95976

Address: 2501 State Farm Rd Tucker, Arkansas 72168

Name of plaintiff: NONE
ADC # NONE

Address: NONE

Name of plaintiff: NONE
ADC # NONE

Address: NONE

This case assigned to District Judge Moody and to Magistrate Judge Ray

In item B below, place the full name of the defendant in the first blank, his official position in the second blank, his place of employment in the third blank, and his address in the fourth blank.

B. Name of defendant: Arkansas Department Of Correction (A.D.C.)

Position: Prison System of Arkansas

Place of employment: Arkansas Dept of Correction

Address: P.O. Box 8707 Pine Bluff, Arkansas 71611

Name of defendant: Mr. Max Mobley

Position: Deputy Director, Health and Correctional Program's

Place of employment: Arkansas Department of Correction

Address: P.O. Box 8707 Pine Bluff, Arkansas 71611

Name of defendant: Correctional Medical Service's (CMS)

Position: Medical Service's for Arkansas Dept of Correction

Place of employment: Arkansas Dept of Correction

Address: P.O. Box 411243 St. Lous, MO. 63141

Name of defendant: Dr. Hugh Burnett

Position: Doctor for CMS./A.D.C./State of Arkansas

Place of employment: Correctional Medical Service's

Address: 10310 W. Markham, #300 LittleRock, Arkansas 72205

II. Are you suing the defendants in:

- ☐ official capacity only
- ☐ personal capacity only
- ☑ both official and personal capacity

III. Previous lawsuits

A Have you begun other lawsuits in state or federal court dealing with the same facts involved in this action?

Yes ___ No ✓

B. If your answer to A is yes, describe the lawsuit in the space below. (If there is more than one lawsuit, describe the additional lawsuits on another piece of paper, using the same outline.)

☐ Parties to the previous lawsuit:

Plaintiffs: NONE

Defendants: NONE

☐ Court (if federal court, name the district; if state court, name the county):

NONE

☐ Docket Number: NONE

☐ Name of judge to whom case was assigned: NONE

☐ Disposition: (for example: Was the case dismissed? Was it appealed? Is it still pending?) NONE

☐ Approximate date of filing lawsuit: NONE

☐ Approximate date of disposition: NONE

IV. Place of present confinement: Tucker Max Unit 2501 State Farm Rd. Tucker, Arkansas 72168

V. At the time of the alleged incident(s), were you:
(check appropriate blank)

____ in jail and still awaiting trial on pending criminal charges

✓ serving a sentence as a result of a judgment of conviction

____ in jail for other reasons (e.g., alleged probation violation, etc.)
explain: NONE

VI. The Prison Litigation Reform Act (PLRA), 42 U.S.C. § 1997e, requires complete exhaustion of administrative remedies of all claims asserted, prior to the filing of a lawsuit. There is a prisoner grievance procedure in the Arkansas Department of Correction, and in several county jails. Failure to complete the exhaustion process provided as to each of the claims asserted in this complaint may result in the dismissal without prejudice of all the claims raised in this complaint.

A. Did you file a grievance or grievances presenting the facts set forth in this complaint?

Yes ✓ No ___

B. Did you completely exhaust the grievance(s) by appealing to all levels within the grievance procedure?

Yes ✓ No ___

If not, why? On a couple I did not because I did not receive a response back to Informal.

VII. Statement of claim

State here (as briefly as possible) the facts of your case. Describe how each defendant is involved. Include also the names of other persons involved, dates, and places. Do not give any legal arguments or cite any cases or statutes. If you intend to allege a number of related claims, number and set forth each claim in a separate paragraph. (Use as much space as you need. Attach extra sheets if necessary.)

* See Attached Page's * of Statement of Claim.

* Page's 1 of 10 *

VIII. Relief

State briefly exactly what you want the court to do for you. Make no legal arguments. Cite no cases or statutes.

$50,000.00 for past pain and suffering and $250,000.00 for future pain and suffering, Legal/Attorney's Fee's, Reimbusted Amount of law suit, corrective surgery to get stone out of Whorton's duct.

I declare under penalty of perjury (18 U.S.C. § 1621) that the foregoing is true and correct.

Executed on this 30 day of August, 2007.

David Felty #95976

David Felty #95976

Signature(s) of plaintiff(s)

Plaintiff: David Felty #95976 (pg. 1 of 10)

- Statement Of Claim -

8/30/07

On July 16, 2000 I wrote a grievance # CU00-4651 in concern's to inadiquit medical care in revalence to medication and timly treatment.

It concern's a salivary stone at the (Whartons duct) in my mouth below my ~~tongue~~ that I wished/wish to have removed and in the time between removal to be placed on antibiotics.

(CMS) Correctional Medical Services responded 8/1/00 by stateing I had been seen by Dr. Casey April 3, 2000, on the response it denotes stone Underneath ~~[illegible]~~ tongue.

Inmates Complaint(s): On or about 4/10/00, I was seen by Dr. Casey concerning a stone in my saliva gland underneath my tongue. Dr. Casey stated that I would have to be scheduled to see (ENT) Ear, Nose and Throat clinic.

Response: In review of your medical record, it is noted that Dr. Casey had written a consultation request for you to go to (ENT) on 4/3/00. You were placed on antibiotic's for ten day's and instructed to return in three week's. I apologize for the delay in getting you scheduled with the (ENT) Specialist. Please continue to watch the lay-in list for your appointment.

Recommendations: "there was nothing written in that space".

Responding Staff: S. Bess, MRS Date: 8/1/00

Follow Up Required ? NO ☒ Yes ☐ Date _____

CMS responded because, on 7/17/00 Warden Hipple of the Arkansas Dept of Correction's (A.D.C.) Cummin's Unit forwarded it to (CMS).

As grievance response # CU00-4651 by (CMS) S. Bess State's there was no "follow-up and no recommendation's".

I did not receive a response in response to grievance

Statement of Claim

CU00-4651 in regards to my request to receive antibiotics due to infection setting in because of the delay in appointment to see the (ENT) specialist throughout the grievance process.

On 8/9/00 I appealed the grievance # CU00-4651 respectfully to the next step in the grievance procedure to (CMS) Deputy / Assistant Director's Decision / Deputy Director, Health and Correctional Program's, Mr. Max Mobley stating: I need to be seen by Dr. Casey, the hole that has been created due to this stone was not mentioned in Mrs. Bess response. this hole is infected and needs to be treated. It can be treated at this level. I need prompt medical attention.

Again this appeal was made 8/9/00 to Mr. Max Mobley Deputy Director, Health and Correctional Programs.

I receive a reply from his office acknowledging receipt of my grievance(# CU00-4651) appeal stating his office would reply with communication by Sept 13, 2000.

On "March 26, 2004" this is the communication I received by: Mr. Max Mobley in concerns to grievance(# CU00-4651).

"Decision: First, I apologize for the lengthly delay in responding to this grievance appeal. It was lost in my office. I have contacted your present unit and found that the appropriate procedure was done and the stone was removed from your saliva gland. Since this issue has been resolved your appeal now has no merit."

"Signed: Mr. Max Mobley 3/26/04"

— NEXT —

From the date that the (10) ten day script for antibiotics was written by: Dr. Casey April 3, 2000 — April 13, 2000, I did not receive additional antibiotics for the infection untill I was transfered to the Calico Rock Unit.

Antibiotics were order within the date's of 10/24/01 — 10/4/02 but I do not have specifics, this was the time I was housed at the Calico Rock Unit.

there were a couple of times within the time 10/4/02 — 4/16/03 at the Grimes Unit I received antibiotics.

Twice at the Grimes' Unit exploritory surgery was performed by an un-known doctor/ dentist, 12/20/02 and on 12/27/02 with granials observed.

These surgery's were on exactly the same location, not at the Whartons Duct on the floor of the mouth where the stone [redacted], but over an (1) inch away on the right lobal area next to my bottom first molar tooth.

I was placed on antibiotics for recovery of this and refered to Dr. Hugh Burnett (ENT).

Prior to this referal and surgery an x-ray report was made by: Laura M. Wrinkle dated: 9/27/2001

" International Radiology Group Inc.
1909 Hi Line Drive
Dallas, Texas. 75207

* there is a calcific density seen inferior to the level of the mandible on the lateral. this could represent a salivary stone. Clinical correlation is recommended. By: M. Clarke, M.D.

Dr. Hugh Burnett noted the infected and dialated Wharton's Duct and the other infected area that the stone had been partially flipping out of the Wharton's Duct and rubbing raw.

X-ray's were ordered #25099 on 3/12/03 with note: "there is no evidence of any lymphadenopathy.

Reason for Study: Repeated swelling of right sub-mandibulary gland."

There was no repeated swelling the swelling and pus substance was present before and after interaction with Dr. Hugh Burnett.

Other date's for x-ray's were 1/17/02 at the Diagnostics Unit where Dye was injected into the Wharton's Duct, 12/20/02 and 12/27/02 other x-ray's were performed at Dr. Hugh Burnett's request.

CT Facial Bones: there is seen a polyp in the right maxillary sinus.

Received July 30, 2003

Mufiz Chauhan, M.D.
Radiologist

No follow-up was done, no boipsy performed of this polyp, by Dr. Burnett.

Dr. Burnett prior to sorgery had x-ray sample ID: 312031579 A (MRI) Magnetic Resonance Imaging done by: Newport Hospital and Clinic, Inc.
2000 Mclain Street Newport, AR. 72112

Dr. Dalal, Jacob Director
Ph: 870-523-6721 Fax 870-523-4437

Prior to surgery Dr. Burnett did not have a biopsy performed by fine-needle aspiration, nor was ductal cannulation performed to remove stone out of Wharton's Duct, It was not dilated to try to remove stone (Wharton's Duct), VIA A TRANSORAL approach being the stone is/was in the proximity of the opening of the Wharton's Duct.

Surgery to excise submandibular gland was performed 4/16/03 By: Dr. Hugh Burnett at South West Hostpital in Little Rock, AR. leaving a 2 3/4 Inch long scar below the jaw line on my neck and the problem stone still inside the opening of the Wharton's Duct.

I have not been able to shave with a razor since the surgery (excised gland), I have a shaving script that allows the use of clippers.

I personally, nor medical personal perform my shaves, but a inmate barber and not daily as I would wish, but once every two weeks.

And that is if I can get (A.D.C.) staff to place me on the barber list, if not resulting in a months worth of facial and neck hair.

By direction of Dr. Hugh Burnett my excised submandibular gland was sent to Oral and Maxillo-facial Pathology laboratory, College of Dentistry - the University of Oklahoma - Health Services Center - Post

— Statement Of Claim — (pg. 6 of 10)

Office Box 26901 Oklahoma City, Ok. 73190, operation #03-945-02.

In the oral pathology laboratory report, it show's that there was "areas of incipient stone formation observed," but no mention of a stone only the begining of formation.

The clinical history indicates that radiographs were submitted with the case, however, none were observed.

The above "clinical history" statement was made by Oral and Maxillofacial Pathology Laboratory on there report, Dr. Burnett did not forward the privious x-ray's, specifically the 9/27/01 International Radiology Group Inc. Report noting "there is a calcific density seen inferior to the level of the mandible on the lateral. this could represent a salivary stone. Clinical correlation is recommended. * X-ray performed by: Laura M. Wrinkle

Pathology By: M. Clarke, M.D.

Again no stone (calcific deposit) was found, only the begining of stone formation's are found in Dr. Burnett Pathology report.

Mr. Max Mobley stated on Grievance #CU 00-4651 that the stone was removed from the saliva gland.

This is not correct the stone is still in place in the opening of the Wharton's Duct, further more the gland is not there for the stone to be removed from it, the gland WAS excisied, no stone formation was found, nor was I personally consulted by him to see if in fact my issue had been address.

In fact, [redacted] (D.F.), the problem stone remains, I still have a pus leakage from

the Wharton's duct and have sharp pain's where the stone roll's and prick's the inside of the Wharton's duct, or pop's out of the Wharton's duct and stick's the bottom of my tongue causing me pain and suffering.

I also have a septic smell due to the infection of the inflamed Wharton's Duct opening into the mouth cavity.

After surgery (excision) I was placed on antibiotic's at the Tucker Max Unit by: Dentist R. Carpenter DDS. and all referal's were defered by: Dr Burnett and A.D.C./CMS Mr: Max Mobley.

On 11/12/04 R. Carpenter DDS on "Written Sick Call Response" states: on 11/8/04 he received my Inmate Complaint: I still have the original stone in my mouth that was to have been taken out by Dr. Burnett. Infection has set in badly in two area's.

Response: I could not get you down to dental clinic today, You are rescheduled for my next clinical day.

Recommendations: If swelling occurs, notify infirmary ASAP. Same for Pain. Follow-Up Required? NO ☒ YES ☐

Date "None Given" By R. Carpenter DDS 11/12/04.

On 5/26/05 while at the Tucker Unit a dentist Parsons Lamont took some occlusal x-ray's and two provided a object in the area in question.

It is now 8/30/07 and all referal's are deferred and I receive no treatment to extract this stone from the Wharton's duct Opening.

— Statement of Claim — (pg. 8 of 10)

Upon a medical review of my jacket to veiw the two occlusal's it is noted that Dr. Burnett has the occlusal's at his office And will return them Greivance #MX #05-01339 ,yet they have yet to be returned.

He did, however, ~~phone~~ this report, Under Consults; 6/30/05 Phone consult with Dr. Burnett - radiopacity on recent occlusal x-ray is a surgical clip from original treatment And is supposed to be there. Dr. Burnett stated that this surgery went very well and there is no need for follow-up.

Note: Copy of today's entry mailed to MSU to be placed in pt jacket.

Pertaining to Mr. Max Mobley Deputy Director, Health And Correctional Program's, it took from 4/3/00 to 3/26/04 to finalize the grievance process which is only suppost to take no more than 90 day's.

Mr. Mobley personally detained my grievance from 8/9/2000 to 3/26/2004

It is my contention(claim) that the stone is still inside the Wharton's Duct and at every level in the chain of custody for grievance and medical services, that treatment has been very un-profetional, inappropriate, inadigute, un-timely and painful as well as harmful to my dental and oral hygeen health, due to infection's in the problem area complained of (Wharton's Duct).

I cannot brush my teeth often due to the pain and suffering of opening my mouth because the toothbrush or the stone roll's around and pricks me or I brush bottom of tongue or floor of mouth to

kill germ's.

I continually have problem's with (A.D.C.) staff because they do not honor my (CMS) medical script to shave with dippers.

then I have verbal confrontation's with (A.D.C.) staff because I am not in compliance with grooming policys.

Excision of the gland in Dr. Burnett's case was not a first or second alternative, after palpitation showed no result's.

Pathophysiology shows that the saliuary glands serve numerous functions, including lubrication; enzymatic degradation of food substances; production of hormones, antibodies, and other blood group - reactive substances; mediation of taste; and antimicrobial protection.

I would think that the excision of the saliva gland (Sublingual) would have come only after he (Dr. Burnett) personally attempted Wharton Ductal removal at the opening into the mouth via a transoral approach, by either cannulation or dilation

this was not a recurrent inflamation, it was present before and after all date's mentioned in this complaint.

Patients with deep intraparenchymal stones or multiple stones should have their gland's excised on an elective basis, neither of which is/was my case.

In my case (Wharton's Duct) and oblique intraoral occlusal view was/would be best used and an attempt to retract stone from Wharton's Duct before excision.

— Statement Of Claim — (10 of 10)

Attached as Exhibits are :1)Grievance # CU00-4651 and all responses. 2) Pathology Report CLIA ID# 37D0855644. 3) Written Sick Call Response By: Dentist R. Carpenter DDS 11/12/04. 4) Pages 1-14 of http://www.emedicine.com/ent/topic598.htm artical on Submandibular Sialadenitis/sialadenosis. 5) #7 Use of Clippers to Shave script's. 6) Informal Resolution #1666. 7) Informal Resolution #1668 8) #3 page's of medically defined word's pertaining to issue. 9) #2 page's from artical by Otolaryngolgy Houston http://gnorayeb.com/Submandibular Stone.html concerning 1- Submandibular Gland Stone's & Ludwig's Angina, 2- Excision of Submandibular gland. 10) Status Assignment Sheet showing date of surgery and date of release from hostpital (South West Hospital in Little Rock) being the same date 4/16/03 11) Patient Wrist Band from date of surgery for excision of submandibular gland MR# 0000153649. 12) Grievance # MX05-01339 and all response's to appeal. 13) Response from J. Stell LPN Grievance Nurse at Tucker Max Unit May 18, 2006 in regards to the two (2) occlusal's that Dr. Burnett never returned that were taken (occlusal x-rays) on 5/26/05 by Parson's Lamont at the Tucker Unit and sent to Dr. Burnett.

- Statement Of Claim -

I further swear that the description of the incident contained herein, is a true, accurate and impartial description to the best of my knowledge, information and belief.

NAME: David Felty

Date: September 1, 2007

David Felty #95976

- Signature -

Subscribed and sworn to before me this 2nd day of SEPTEMBER, 2007.

Notary Public

My Commission Expires: 9-30-2007

Exhibit # ___ C-800-5

CONFIDENTIAL

RECEIVED OFFICE OF THE DEPUTY DIRECTOR

AUG 16 2000

ATTACHMENT I

GRIEVANCE FORM

UNIT/CENTER Cummins

For Office Use Only

[redacted]

RECEIVED

JUL 17 2000

Date Received

CUMMINS UNIT GRIEVANCE OFFICE

NAME (Please Print) David Felty ADC # 95976

HEALTH & CORRECTIONAL PROGS. AR DEPT. OF CORRECTION

BARRACKS East Building JOB ASSIGNMENT Punitive; North #20

Have you discussed this problem with your immediate supervisor? YES ✓ NO ___ NATURE OR DESCRIPTION OF THE PROBLEM:

On or, about 4/10/00, I was sent by Dr. Casey concerning a stone ive had in my salava gland underneath my toung. Dr. Casey stated I would have to be scheduled to see a nose + throat

WHAT DO YOU WANT TO HAPPEN TO SOLVE IT?

specialist. After this about a month went by + I placed another sick call to see Dr. Casey in the sick call box, he veiwed me about

Inmate Signature David Felty #95976 Date 7/16/00

IS THIS AN EMERGENCY SITUATION? YES √ NO ___ If so, why? (Provide Explanation) ___

two week's later + aduised me, that the nose + throat specialist the A.D.C. has been - (NEXT)

(An emergency situation is one in which you may be subject to a substantial risk of physical harm. It should not be declared for ordinary problems that are not of a serious nature.) If you marked yes, you may give this completed form to any officer or department employee who shall sign the attached emergency receipt, give you the receipt, and deliver it without undue delay to the ARO, the Warden/Center Supervisor or, in their absence, to the Unit/Center Assistant Warden. REPRISALS: If you are harmed or threatened because of your use of the grievance form, report it immediately to the Warden.

(To be filled out by Receiving Officer)

RECEIPT FOR EMERGENCY SITUATIONS

OFFICER (Please Print) Bonnie Jones

FROM WHICH INMATE? David Felty ADC # 95976

DATE 7-16-00 TIME 10:40 pm

Bonnie Jones

Signature of Receiving Officer

Exhibit # ___ C-800-5

ATTACHMENT I

GRIEVANCE FORM

UNIT/CENTER Cummins

For Office Use Only

_____

Date Received

NAME (Please Print) David Felty ADC # 95976

BARRACKS East Building JOB ASSIGNMENT Punitive; North #20

Have you discussed this problem with your immediate supervisor? YES ✓ NO ___ NATURE OR DESCRIPTION OF THE PROBLEM:

useing has quit takeing pateint's. He did aduise there was someone they were planning to start useing. Since these time's ive spoke of, ive place at the minimum 10 sick call's in there appropriate

WHAT DO YOU WANT TO HAPPEN TO SOLVE IT?

box to be see due to infection setting in my mouth & a hole being created in my gum line due to this infection. None of these 10 sick

Inmate Signature David Felty #95976 Date 7/16/00

IS THIS AN EMERGENCY SITUATION? YES ✓ NO ___ If so, why? (Provide Explanation) _____

Call's have been answered. It has been 3 month's to organize a trip to a nose & throat - (NEXT)

(An emergency situation is one in which you may be subject to a substantial risk of physical harm. It should not be declared for ordinary problems that are not of a serious nature.) If you marked yes, you may give this completed form to any officer or department employee who shall sign the attached emergency receipt, give you the receipt, and deliver it without undue delay to the ARO, the Warden/Center Supervisor or, in their absence, to the Unit/Center Assistant Warden. REPRISALS: If you are harmed or threatened because of your use of the grievance form, report it immediately to the Warden.

(To be filled out by Receiving Officer)

RECEIPT FOR EMERGENCY SITUATIONS

OFFICER (Please Print) Ronnie Jones

FROM WHICH INMATE? David Felty ADC # 95976

DATE 7-16-00 TIME 10:00 am

Ronnie Jones

Signature of Receiving Officer

(Page [redacted] Exhibit # ___)

C-800-5

ATTACHMENT I

GRIEVANCE FORM

UNIT/CENTER Cummin's

For Office Use Only

#_____

Date Received

NAME (Please Print) David Felty ADC # 95976

BARRACKS East Building JOB ASSIGNMENT Punitive; North #20

Have you discussed this problem with your immediate supervisor? YES ✓ NO ___ NATURE OR DESCRIPTION OF THE PROBLEM:

specialist, wouldn't the common thing to due is see me the patient + set me back up on Antibiotic's, being I WAS giving them the first time I was seen due to infection?

WHAT DO YOU WANT TO HAPPEN TO SOLVE IT?

I want to be taken promptly to a nose + throat specialist + have these stone's taken out. In the mean time seen by medical staff +

Inmate Signature David Felty #95976 Date 7/16/00

IS THIS AN EMERGENCY SITUATION? YES ✓ NO ___ If so, why? (Provide Explanation) _____

be treated. This is an emergency due to infection has set in my mouth because of lack of profetionalizime in C.M.S. at the Cummins Unit.

(An emergency situation is one in which you may be subject to a substantial risk of physical harm. It should not be declared for ordinary problems that are not of a serious nature.) If you marked yes, you may give this completed form to any officer or department employee who shall sign the attached emergency receipt, give you the receipt, and deliver it without undue delay to the ARO, the Warden/Center Supervisor or, in their absence, to the Unit/Center Assistant Warden. REPRISALS: If you are harmed or threatened because of your use of the grievance form, report it immediately to the Warden.

(To be filled out by Receiving Officer)

RECEIPT FOR EMERGENCY SITUATIONS

OFFICER (Please Print) Ronnie Jones

FROM WHICH INMATE? David Felty ADC # 95976

DATE 7-16-00 TIME 10:00 AM

Ronnie Jones

Signature of Receiving Officer

Exhibit #

CMS GRIEVANCE RESPONSE

300

Grievance #[redacted]-4651

Inmate: Felty, David	ADC#: 95976	DOB:
Facility: CUMMINS	Barracks: EB	
Letter Date: 7/17/00	Date Infirmary Recd: 7/18/00	Response Date: [redacted]

Interview: Required	X Deferred

Inmate's Complaints: On or about 4/10/00, I was seen by Dr. Casey concerning a stone I've in my saliva gland underneath my tongue. Dr. Casey stated that I would have to be scheduled to see ENT.

Response: In review of your medical record, it is noted that Dr. Casey had written a consultation request for you to go to ENT on 4/3/00. You were placed on antibiotics for ten days and instructed to return in three weeks. I apologize for the delay in getting you scheduled with the ENT specialist. Please continue to watch the lay-in list for your appointment.

Recommendations:

Responding Staff: SBess [redacted]

Original - ADC Grievance Officer
Copy - Inmate
Copy - File

Follow Up Required? No x Yes ☐ Date _____

Exhibit #_____

C-800-6

Attachment II [redacted]

INMATE NAME Felty, D ADC # 95976 GRIEVANCE #_____

WARDEN'S/CENTER SUPERVISOR'S DECISION

I have determined that your grievance is a medical matter. Therefore, I have forwarded your grievance to the Unit Infirmary Manager who will provide a written response or will interview you within 20 working days. Please do not appeal this grievance until the infirmary supervisor has spoken with you, until you have received a response, or the time limit has expired. If you appeal this grievance, you should attach the Infirmary Manager's response to your appeal. Failure to do so may result in your grievance being returned to you for this information before it can be responded to.

If you do not agree with my response, you may appeal this decision to the appropriate Assistant Director within ten (10) working days.

[redacted] [redacted] [redacted]

Signature of ARO or Warden's/Supervisor's Designee | Title | Date

INMATE'S APPEAL

If you are not satisfied with this response, you may appeal this decision within five days by filling in the information requested below and mailing it to the appropriate Deputy/Assistant Director. Keep in mind that you are appealing the decision to the original complaint. Do not list additional issues which are not a part of your complaint.

WHY DO YOU NOT AGREE WITH THE RESPONSE?

I need to be seen my Dr. Casey, [redacted] the hole that has been created due to this stone was not mentioned in Mrs. Bess response. This hole is infected & need's to be treated. It can be treated at this level. I need prompt medical attention.

D Felty | #95976 | 8-9-2000

Inmate Signature | ADC # | Date

 Exh. B, 1 #

Attachment IV

ACKNOWLEDGMENT OF GRIEVANCE

TO: Inmate Felty, David ADC# 95976

FROM: [redacted] TITL[redacted]

RE: Notification of Grievance Received. Grievance #[redacted]

DATE: August 18, 2000

Please be advised, I have received your Grievance dated July 16, 2000

on August 16, 2000

You will receive communication from this office regarding the Grievance

by Sept. 13, 2000

Signature of Grievance Officer/ARO

CHECK ONE OF THE FOLLOWING

_____ This Grievance is of a medical nature and has been forwarded to infirmary staff.

_____ This Grievance has been determined to be an emergency situation, as you so indicated.

Action Taken: _____

_____

__✓__ This Grievance has been determined to not be an emergency situation because you would not be subject to a substantial risk of personal injury or other serious irreparable harm. Your Grievance will be processed as a Non-Emergenc .

Warden/Center Supervisor's Signature

Deputy/Assistant Director or Director's Signature

 Exhibit #____

Back of Attachment II

Felty, David 95976 [redacted]

INMATE NAME_____ **ADC**_____ **GRIEVANCE**_____

[redacted]

First, I apologize for the lengthy delay in responding to this grievance appeal. It was lost in my office. I have contacted your present unit and found that the appropriate procedure was done and the stone was removed from your saliva gland. Since this issue has been resolved your appeal now has no merit.

SIGNATURE

3-26-04
DATE

Please be advised that if you appeal this decision to the U. S. District Court a copy of this Deputy/Assistant Director must be attached to any petition or complaint or the Court must dismiss your case without notice. You shall also be subject to paying filing fees pursuant to the Prison Litigation Act of 1995.

 Exh. bit #___

ORAL AND MAXILLOFACIAL PATHOLOGY LABORATORY

COLLEGE OF DENTISTRY
THE UNIVERSITY OF OKLAHOMA
HEALTH SCIENCES CENTER

Post Office Box 26901
Oklahoma City, OK 73190
Telephone (405) 271-4333
Fax (405) 271-3385

CLIA ID# 37D0856444

PATIENT NAME		OP NUMBER
	Felty, David	03 945 02
ADDRESS	CMS/PO Box 411243	
	St. Louis, MO 63141	
SUBMITTED BY	Dr. Hugh Burnett	DATE SUBMITTED 4/16/03
ADDRESS	10310 W. Markham, #300	DATE RECEIVED 4/17/03
	Little Rock, AR 72205	DATE PRINTED 4/18/03

CLINICAL HISTORY	AGE	SEX	RACE	SOCIAL SECURITY #	DOB
	33	M	C	ADC #095976	1-14-70

This 33 year old caucasian male presents with swelling involving the right submandibular gland. Operation: excision. Clinical impression: sialadenitis and sialolithiasis. The clinical history indicates that radiographs were submitted with the case, however, none were observed.

Gross Description: Received in formalin is a fragment of brown-white soft tissue which measures 4 x 2 x 2 cm. The specimen is multisected and representative sections are submitted in cassettes #'s 1, 2, 3, 4, and 5. GDH/kl

Microscopic Description: Sections reveal a soft tissue specimen composed of submandibular salivary gland. The gland is composed of both mucous and well as serous acini. Areas of fatty infiltration, fibrosis, an infiltrate of chronic inflammatory cells, ductal ectasia, and areas of incipient stone formation are observed.

PATHOLOGIC DIAGNOSIS

Right submandibular gland, excision: benign salivary gland exhibiting chronic sialadenitis with incipient sialolithiasis.

96 EB 4/18/03

Glen D. Houston

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210-7 0 0-33 1 GDH ICD-9:527.2

WRITTEN SICK CALL RESPONSE

Exhibit #___

Inmate: Felty, David ADC # 95976 DOB: 1-14-70

Facility: Maximum Security Unit Barracks: #

Sick Call Date: 11-8-04 Date Recvd in Infirmary: 11-12-04 Response Date: 11-12-04

Inmate's Complaints: I still have the original stitch in my mouth that was to have been taken out by Dr Burnett. Infection has set in badly in two areas.

Response: I could not get you down to dental clinic today. You are re-scheduled for my next clinical day.

Recommendations: If swelling occurs, notify infirmary ASAP. Use for pain.

R. Carpenter DDS 11-12-04
Nurse Date

Original - Inmate
Copy - Medical Record

Follow Up Required? No ☒ Yes ☐ Date _____

Submandibular Sialadenitis/Sialadenosis

Last Updated: November 18, 2003

Synonyms and related keywords: sialolithiasis, Sjögren disease, Sjögren syndrome, Sjogren disease, Sjogren syndrome

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AUTHOR INFORMATION

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INTRODUCTION

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Background: Sialadenitis of the submandibular gland is a relatively commonly

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encountered yet infrequently discussed topic. Causes range from simple infection to autoimmune etiologies. Although not as frequent as sialadenitis of the parotid gland, it represents an important area of clinical relevance to the otolaryngologist and other specialists. The following discusses the basic science of the submandibular gland, as well as the more common causes of sialadenitis and sialadenosis of the submandibular gland.

Anatomy

The submandibular gland, along with the parotid and sublingual glands, comprise the major salivary glands. The minor salivary glands are scattered along the upper aerodigestive tract, including the lips, mucosa of the oral cavity, pharynx, and hard palate.

The submandibular gland is the second largest (approximate weight, 10 g) of the major salivary glands (the parotid gland is the largest). Anatomically, it is situated in the submandibular triangle of the neck.

The gland itself can be arbitrarily divided into superficial and deep lobes based on its relationship to the mylohyoid muscle, the former lying superficial to the muscle, and the latter wrapping around the posterior aspect of the muscle. The gland itself lies on the hyoglossus muscle, superficial to both the hypoglossal and the lingual nerves, the latter supplying parasympathetic innervation by way of the chorda tympani nerve (from cranial nerve VII) and the submandibular ganglion. The duct of the submandibular gland, also known as the Wharton duct, exits the gland from the deep lobe, passing through the floor of the mouth, and opening in close proximity to the lingual frenulum.

Pathophysiology: The salivary glands serve numerous functions, including lubrication; enzymatic degradation of food substances; production of hormones, antibodies, and other blood group–reactive substances; mediation of taste; and antimicrobial protection. The regulation of salivary flow is primarily through the autonomic system and, most importantly, the parasympathetic division. In the case of the submandibular gland, this is mediated through the submandibular ganglion. Presynaptic fibers are derived from the superior salivatory nucleus and carried by the chorda tympani nerve, which joins the lingual nerve traveling towards the ganglion. Postsynaptic fibers extend from the ganglion to the gland itself.

Saliva is produced in the glandular subunit. The fluid component of the saliva is derived from the perfusing blood vessels in proximity to the gland, while the macromolecular composition is derived from secretory granules within the acinar cells. The saliva is produced in the acinus. Myoepithelial cells, containing contractile elements, are located along the periphery of the acinus. Upon contraction of these myoepithelial cells, the saliva is secreted into the ductal system.

The exact mechanism of salivary secretion is not completely understood but is believed to be under the influence of a cyclic AMP (adenosine 3,'5'-cyclic monophosphate) and a calcium-activated phosphorylation mechanism. The salivary secretions are then modified by a variety of cell types along a series of ducts, including the striated, intercalated, and excretory ducts, before finally being excreted through the Wharton duct into the oral cavity.

The concentration of mucus is higher in the submandibular gland, accounting

for the viscous nature of its secretions relative to the other salivary glands. This increased viscosity, and subsequent relatively slower flow, contributes to the propensity for salivary gland calculi and stasis in certain disease states.

Frequency:

- **In the US:** The exact frequency of submandibular sialadenitis is unclear. The incidence of acute suppurative parotitis has been reported at 0.01-0.02% of all hospital admissions. The submandibular gland is suggested to account for approximately 10% of all cases of sialadenitis of the major salivary glands. Extrapolation would suggest an incidence of 0.001-0.002%, but this is unconfirmed.

Race: No race predilection per se exists.

Sex: No sex predilection per se exists.

Age: Although no obvious age predilection exists, per se, sialadenitis as a whole tends to occur in the older, debilitated, or dehydrated patient.

History: Submandibular sialadenitis takes several forms. The diagnostic workup of any submandibular enlargement begins with a thorough history. This should include onset, duration of symptoms, recurrence, recent operative history, recent dental work, and thorough drug history, immunization history (specifically measles, mumps, rubella [MMR] vaccine), past medical (specifically autoimmune) history, past surgical history, and history of radiation therapy. Inquire as to associated fever or chills, weight loss, presence of a mass, bilaterality or unilaterality, skin changes, lymphadenopathy, keratitis, shortness of breath, oral discharge, dental pain, or skin discharge.

Physical: Physical examination should begin with the gland itself. The gland should be palpated for the presence of calculi. Examine the ductal opening for purulence. Palpation should extend into the floor of mouth as well as the soft tissue of the tongue, cheek, and neck. Lingual papillary atrophy should be looked for, as well as loss of enamel from the tooth surface (the latter may be associated with bulimia). All of the major salivary glands should be examined for masses, symmetry, and the presence of discharge. The presence of lymphadenopathy should be noted. The eyes should be examined for any presence of interstitial keratitis. A quick cranial nerve examination should be conducted with particular attention to cranial nerves VII and XII. The lungs should be examined and a chest radiograph ordered if suspected pulmonary involvement exists.

Causes:

- Acute sialadenitis: Acute sialadenitis is an acute inflammation of a salivary gland.
    - Patients typically present with erythema over the area, pain, tenderness upon palpation, and swelling. Frank cellulitis and

Exhibit #____

induration of adjacent soft tissues may be present. Purulent material may be observed being expressed from the Wharton duct, particularly upon milking the gland. Rarely, a cutaneous fistula may occur, with spontaneous drainage of purulent material. The inflammation is secondary to an infectious process.

- The most common organism is *Staphylococcus aureus*. Other bacterial organisms include *Streptococcus viridans, Haemophilus influenzae, Streptococcus pyogenes,* and *Escherichia coli*. The infection is often the result of dehydration with overgrowth of the oral flora. The most common causes are postoperative dehydration, radiation therapy, and immunosuppression (eg, diabetes mellitus, organ transplant, chemotherapy, human immunodeficiency virus).

- Of note, infection of the submandibular gland is rare in the neonate and prepubescent child. When it does occur, similar pathogens have been identified, including *Pseudomonas aeruginosa* and group B streptococci. Physical examination, in addition to the symptoms described above, includes failure to thrive and irritability. Progression may occur, involving the contralateral gland. The etiology of this entity is unclear.

- Although less common than bacteria, several viruses have been implicated in submandibular sialadenitis. These include the mumps virus, which typically affects the parotid gland but can affect the submandibular gland as well. Other viruses include HIV, coxsackievirus, parainfluenza types I and II, influenza A, and herpes.

- Infection of the submandibular gland can result in the formation of a submandibular abscess. In this state, the patient may appear toxic, with features similar to acute submandibular sialadenitis. Spiking fevers are not uncommon. This is a serious condition requiring strict attention because of the possibility that the abscess may spread to involve other deep neck spaces of the neck. Trismus may be indicative of parapharyngeal involvement. Progression to Ludwig angina, a life-threatening infection of the submental and sublingual spaces, although rare, can occur.

- Chronic sialadenitis: Chronic sialadenitis, in contrast, is typically less painful and is associated with recurrent enlargement of the gland (often following meals) typically without erythema. The chronic form of the disease is associated with conditions linked to decreased salivary flow, rather than dehydration. These conditions include calculi, salivary stasis, and a change in the fluid and electrolyte composition of the gland.

- Sialolithiasis: Salivary calculi (sialolithiasis) relate to the formation and deposition of concretions within the ductal system of the gland.

  - Eighty percent of all salivary calculi occur in the submandibular gland, with approximately 70% of these demonstrable as radio-opacities on routine plain radiography consisting of intraoral occlusal radiographs.

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- The calculi vary in size and may be single or multiple. The formation of calculi is associated with chronic sialadenitis, and in particular, the recurrent nature of the problem.
- The exact mechanism of stone formation is unclear, but it appears to be related to the following conditions:
  - Salivary stagnation
  - Epithelial injury along the duct resulting in sialolith formation, which acts as a nidus for further stone formation
  - Precipitation of calcium salts
- The stones themselves are typically composed of calcium phosphate or calcium carbonate in association with other salts and organic material such as glycoproteins, desquamated cellular residue, and mucopolysaccharides.
- Patients most often present with a colicky postprandial swelling of the gland. The course of the disease is typically relapsing and remitting until a final definitive treatment, usually in the form of surgery, is undertaken.

- Autoimmune sialadenitis: Autoimmune diseases, in particular Sjögren syndrome, can be associated with sialadenitis. Although preferentially affecting the parotid gland, the submandibular and minor salivary glands are also affected. The disease, which is associated with keratoconjunctivitis sicca, xerostomia, salivary gland enlargement, and lingual papillary atrophy, is confirmed through biopsy of the minor salivary glands of the lip. Numerous laboratory tests are also used to confirm the diagnosis, such as autoantibodies Sjögren syndrome A (SS-A) and Sjögren syndrome B (SS-B), rheumatoid factor, and antinuclear antibodies.
- Sialadenosis: Sialadenosis refers to nonneoplastic noninflammatory swelling in association with acinar hypertrophy and ductal atrophy.
  - Etiologies fall into 5 major categories.
    - Nutritional (eg, vitamin deficiency, bulimia)
    - Endocrine (eg, diabetes mellitus, hypothyroidism)
    - Metabolic (eg, obesity, cirrhosis, malabsorption)
    - Inflammatory/autoimmune (eg Sjögren disease, Heerfordt syndrome)
    - Drug induced (eg, thiourea)
  - Physical examination shows a nontender swelling that is often bilateral and symmetric but can be unilateral and asymmetric.

Exhibit # _____

DIFFERENTIALS

Other Problems to be Considered:

The differential diagnosis of submandibular sialadenitis and sialadenosis includes the following:

Infectious (acute) cause - Bacterial or viral disease

Inflammatory cause - Sialolithiasis, radiation-induced disease

Autoimmune cause - Sjögren disease, lupus

Granulomatous cause - Tuberculosis, tularemia, sarcoidosis, catscratch disease, actinomycosis

Drug-related cause - Thiourea

Neoplastic (benign) cause - Pleomorphic/monomorphic adenoma, oncocytoma, ductal papilloma, hemangioma, foreign body, ranula, lymphoepithelial cyst

Neoplastic (malignant) cause - Adenoid cystic carcinoma, mucoepidermoid carcinoma, adenocarcinoma, undifferentiated carcinoma, malignant oncocytoma, squamous cell carcinoma

Endocrine cause - Hypothyroidism, diabetes mellitus

Metabolic cause - Vitamin deficiency, cirrhosis, obesity, bulimia, malabsorption

WORKUP

Lab Studies:

- In evaluating the patient with sialadenitis, steps should be taken in the following order: history, physical examination, culture, laboratory investigation, radiography, and if indicated, fine-needle aspiration biopsy (see History and Physical).
- Laboratory investigations should begin with culture of the offending gland (if possible, prior to the administration of antibiotics).
- Blood cultures should be obtained in the patient exhibiting bacteremia or sepsis.
- As a rule, needle aspiration of a suspected abscess is not indicated.
- Routine electrolytes and complete blood cell count with differential should be obtained to assess for any evidence of dehydration or systemic infection.

Exhibit #____

- If a diagnosis of autoimmunity is entertained, serum analysis for antinuclear antibody, SS-A, SS-B, and erythrocyte sedimentation rate should be conducted.

Imaging Studies:

- Numerous radiologic techniques are available in submandibular imaging. Deciding which study to obtain first is often difficult. Examination selection should be based in part on the suspected cause of the problem. The authors' institution tends to begin with plain radiography, followed by the use of computed tomography scanning with combined sialography.
- Of all the radiologic examinations available, one of the simplest is conventional plain radiography. Anteroposterior, lateral, and oblique intraoral occlusal views are used. This technique is particularly valuable in evaluating the presence of calculi, which are radio-opaque in approximately 70% of cases. These radiographs are limited in that they do not provide any information about the ductal system or soft tissues.
- Sialography can be used to evaluate sialolithiasis or other obstructive entities, as well as inflammatory and neoplastic disease.
  - In this technique, a water-soluble medium such as meglumine diatrizoate is injected into the Wharton duct and lateral, oblique, and anteroposterior plain radiographs are obtained in order to assess the ductal arborization.
  - Contraindications for this test are iodine allergy and acute sialadenitis.
  - Any filling defects (eg, calculi), retained secretions (eg, chronic sialadenitis), stricture formation (eg, inflammation), extravasation (eg, Sjögren disease), or irregularly contoured borders (eg, neoplasm) are noted.
- Ultrasonography can be used to differentiate between solid versus cystic lesions of the gland. It can also be used to differentiate intrinsic from extrinsic disease and can be helpful in identification of abscess formation.
- Computed tomography scanning is an excellent modality in differentiating intrinsic versus extrinsic glandular disease. It is also extremely valuable in defining abscess formation versus phlegmon. It is limited in evaluating the ductal system unless combined with simultaneous sialography.
- Magnetic resonance imaging is of little utility in sialadenitis or sialadenosis. It does not allow evaluation of the ductal system, and it is not helpful in defining calcifications. It is an excellent tool for soft tissue definition and is invaluable in instances of suspected neoplasia.

Procedures:

- Fine-needle aspiration and biopsy
  - Open biopsy of the lip should be considered when the diagnosis of Sjögren disease is contemplated.
  - If suspicion of a solid neoplasm masquerading as sialadenitis is significant, a fine-needle aspiration with biopsy should be undertaken. The management and differential diagnosis of submandibular neoplasms is beyond the scope of the current discussion.

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Exhibit H

Medical Care: Management of submandibular sialadenitis and sialadenosis involves a wide range of approaches, from conservative medical management to more aggressive surgical intervention.

- One management scheme is as follows:
  - Acute sialadenitis
    - Medical management - Hydration, antibiotics (oral versus parenteral), warm compresses and massage, sialogogues
    - Surgical management - Consideration of incision and drainage versus excision of the gland in cases refractory to antibiotics, incision and drainage with abscess formation, gland excision in cases of recurrent acute sialadenitis
  - Salivary calculi
    - Medical management - Hydration, compression and massage, antibiotics for the infected gland
    - Surgical management - Duct cannulation with stone removal, gland excision in recurrent cases
  - Sjögren disease
    - Medical management - Hydration, dental hygiene, rheumatology and dental referral
    - Surgical management - Gland excision not usually needed unless recurrent acute sialadenitis
  - Sialadenosis
    - Medical management - Treatment of underlying cause
    - Surgical management - Not indicated
- Medical management centers on eliminating the causative factor.
  - Acute sialadenitis
    - In cases of acute sialadenitis, adequate hydration should be ensured and electrolyte imbalances corrected.
    - Patients are most often treated on an outpatient basis, with the administration of a single dose of parenteral antibiotics in an emergency department, followed by oral antibiotics for a period of 7-10 days. Clindamycin (900 mg IV q8h or 300 mg PO q8h) is an excellent choice and provides good coverage against typical organisms.
    - Patients who exhibit significant morbidity, are significantly dehydrated, or are septic should be admitted to hospital. In this latter group of patients, CT scanning of the area should be performed. If a large abscess is noted, incision and drainage should be considered. Small abscesses typically respond to conservative methods.
    - In cases refractory to antibiotics, viral and atypical bacterial causes should be considered.

Exhibit #

- Sialolithiasis
  - Patients with sialolithiasis should be initially treated with hydration, warm compresses, and gland massage.
  - Antibiotics are indicated in patients exhibiting infection.
- Sjögren disease
  - In those patients with Sjögren disease, hydration and prevention of complications should be undertaken.
  - Dental hygiene should be strictly maintained in order to prevent carries, and dental and rheumatology consults should be sought. Gland excision is rarely indicated.
- Sialadenosis: Sialadenosis should be managed expectantly. Treatment should be directed towards managing the underlying problem and achieving homeostasis. Gland excision is not indicated.

Surgical Care:

- Acute sialadenitis
  - Patients who exhibit significant morbidity, are significantly dehydrated, or are septic should be admitted to hospital. In this latter group of patients, CT scanning of the area should be performed. If a large abscess is noted, incision and drainage should be considered. Small abscesses typically respond to conservative methods.
  - In patients with recurrent acute attacks, gland excision during a period of quiescence should be considered. Serial CT scanning is often useful.
- Sialolithiasis
  - In patients with calculi in proximity of the opening of the Wharton duct, the duct can be cannulated, dilated, and the stone removed via a transoral approach.
  - Patients with deep intraparenchymal stones or multiple stones should have their glands excised on an elective basis. Ultrasonic lithotripsy is rarely effective and is not offered at the authors' institution.

The goals of pharmacotherapy are to eradicate the infection, reduce morbidity, and prevent complications.

Drug Category: *Antibiotics* – Therapy must cover all likely pathogens in the context of this clinical setting.

Drug Name	Clindamycin (Cleocin) – Lincosamide for treatment of serious skin and soft tissue staphylococcal infections. Also effective against aerobic and anaerobic streptococci

Exhibit #

	(except enterococci). Inhibits bacterial growth, possibly by blocking dissociation of peptidyl tRNA from ribosomes, causing RNA-dependent protein synthesis to arrest.
Adult Dose	900 mg IV q8h 300 mg PO q8h
Pediatric Dose	Not established
Contraindications	Documented hypersensitivity; regional enteritis; ulcerative colitis; hepatic impairment; antibiotic-associated colitis
Interactions	Increases duration of neuromuscular blockade induced by tubocurarine and pancuronium; erythromycin may antagonize effects of clindamycin; antidiarrheals may delay absorption of clindamycin
Pregnancy	B - Usually safe but benefits must outweigh the risks.
Precautions	Adjust dose in severe hepatic dysfunction; no adjustment necessary in renal insufficiency; associated with severe and possibly fatal colitis by allowing overgrowth of *Clostridium difficile*

Further Inpatient Care:

- Patients requiring inpatient management should be monitored on a daily basis and preferably twice daily.
- In order to ascertain the progression or improvement of acute sialadenitis, serial CT scanning may be warranted.
- Patients with sialolithiasis should be treated conservatively during the acute exacerbation stage and should be monitored after discharge for definitive surgical intervention.

Further Outpatient Care:

- For patients with acute sialadenitis not requiring admission, follow-up visit should be 3 days from the first visit and then 1 week later (with improvement).
- Patients with chronic sialadenitis/sialolithiasis and autoimmune sialadenitis or sialadenosis should be seen on a regular basis and if acute exacerbation of the problem occurs.

In/Out Patient Meds:

- In addition to the antibiotics, patients may be treated with any form of nonsteroidal anti-inflammatory medications. Narcotics may be needed in severe cases, and increasing pain

Exhibit #

refractory to medications is often an indication for admission for further evaluation.

- In addition, medications predisposing to xerostomia should be avoided where possible. These include antiparkinsonian, antiemetics, antinauseants, over-the-counter and prescription cold medications, antidepressants, antihypertensive agents, diuretics, anticholinergics, antianxiety agents, and decongestants.

Complications:

- The most serious complication of acute sialadenitis is the formation of an abscess. Management is described above.
- Complications of chronic sialadenitis and autoimmune sialadenitis are most often dental in nature because of the decreased function of the gland and the protective effect provided against caries.
- Chronic inflammation of the gland with or without calculi often renders the gland difficult to excise because of the loss of normal tissue planes.

Prognosis:

- The prognosis of acute sialadenitis is very good. Most cases are easily treated with conservative medical management, and admission is the exception, not the rule. Acute symptoms resolve within 1 week; however, edema in the area may last several weeks.
- Postsurgery, patients are often already admitted with appropriate intravenous antibiotics. These patients have a similar prognosis.
- Patients with chronic sialadenitis often have a relapsing and remitting course. Prognosis is dependent on the etiology.
- Patients with sialolithiasis require definitive surgical treatment in most cases, which results in an excellent prognosis.
- Patients with Sjögren or other autoimmune diseases are likely to have a protracted course related to systemic involvement.
- Patients with sialadenosis have a good prognosis, if their underlying problem is adequately controlled. Even if control is attained, bilateral swelling may be persistent.

Patient Education:

- Patients with any form of sialadenitis should be educated as to the value of hydration and excellent oral hygiene. This lessens the severity of the attacks and prevents dental complications. Patients with sialadenosis should be educated regarding the mechanism of their underlying pathology and methods of maintaining control over them.
- eMedicine has excellent patient education resources about dental and oral health available at http://www.emedicinehealth.com/collections/1601.asp. All these resources may be printed free of charge.

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Caption: Picture 1. Submandibular sialadenitis/sialadenosis. Submandibular

Exhibit #___

calculus.

View Full Size Image

eMedicine Zoom View (Interactive!)

Picture Type: Image

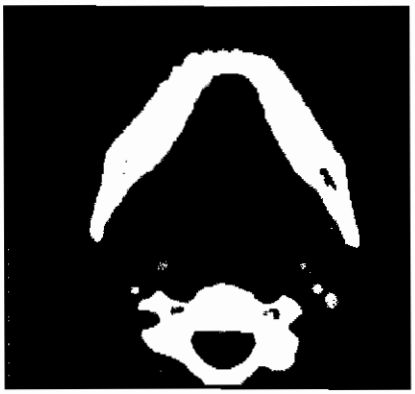
Caption: Picture 2. Submandibular sialadenitis/sialadenosis. Sialogram with stenosis secondary to chronic sialadenosis.

View Full Size Image

eMedicine Zoom View (Interactive!)

Picture Type: X-RAY

Caption: Picture 3. Submandibular sialadenitis/sialadenosis. Submandibular abscess and associated Ludwig angina.



View Full Size Image

eMedicine Zoom View (Interactive!)

Picture Type: Image

Caption: Picture 4. Submandibular sialadenitis/sialadenosis. Submandibular neoplasm.

View Full Size Image

Exhibit #

eMedicine Zoom View (Interactive!)

Picture Type: Image

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ARKANSAS
DEPARTMENT OF CORRECTION (REV. 07/93)

MEDICAL RESTRICTIONS/
LIMITATIONS/SPECIAL AUTHORIZATIONS

MSF-207

RESTRICT INMATE FROM:

PART 1 RESTRICTIONS:

___ ASSIGNMENTS REQUIRING STRENUOUS PHYSICAL ACTIVITY FOR PERIODS IN EXCESS OF _____ HOURS.

___ ASSIGNMENT REQUIRING PROLONGED CRAWLING, STOOPING, RUNNING, JUMPING, WALKING OR STANDING.

___ ASSIGNMENT REQUIRING HANDLING/LIFTING OF HEAVY MATERIALS IN EXCESS OF _____ POUNDS OR REQUIRING OVERHEAD WORK FOR A PERIOD IN EXCESS OF _____ HOURS.

INMATE REQUIRES:

PART 2 LIMITATIONS:

*___ BED REST _____ DAYS REASON: _____

___ NO DUTY _____ DAYS REASON: _____

___ NO YARD CALL _____ DAYS REASON: _____

___ NO SPORTS _____ DAYS REASON: _____

___ ONE ARM/HAND DUTY _____ DAYS

INMATE IS AUTHORIZED TO:

PART 3 SPECIAL AUTHORIZATIONS:

___ REPORT TO THE INFIRMARY FOR SPECIAL TREATMENTS (_____ TIME)

___ SOAK: _____

___ EXERCISE: _____

___ OTHER: _____

___ BATHE IN THE INFIRMARY

___ SITZ BATH

___ CAST

___ OTHER: _____

___ HAVE IN POSSESSION:

___ CANE

___ CRUTCHES

___ BRACE: (DESCRIBE BRIEFLY) _____

___ PRESCRIBED FOOTWEAR: _____

___ ORTHOPEDIC APPLIANCE: (DESCRIBE BRIEFLY) _____

___ OTHER: Use clippers to shave facial hair as in ARK today

*___ GO TO DINING/PILL WINDOW/SHOWER ONLY

THIS MEDICAL RESTRICTION(S)/LIMITATION(S)/SPECIAL AUTHORIZATION(S) STARTS: 8/15/03 (DATE) 1200 hrs (TIME (MILITARY))

THIS MEDICAL RESTRICTION(S)/LIMITATION(S)/SPECIAL AUTHORIZATION(S) ENDS: 12/31/03 (DATE) 2400 hrs (TIME (MILITARY))

SIGNATURE OF MEDICAL STAFF

DISTRIBUTION:
ORIGINAL - MEDICAL JACKET
PINK - SECURITY
YELLOW - CLASSIFICATION
BLUE - INMATE

NAME: David Felty
DOB: _____
ADC#: 95976

Exh. B-1 #

Arkansas Department of Correction
RESTRICTION/MEDICAL PASS ORDER

Inmate (Last Name, First Name, MI): **Felty, David L.** ADC #: **095976**
Facility: Maximum Security Unit
Site: MAX
Completed by: Edna Seals
Encounter date: 1
2/30/2003

Restrictions

No shaving effective from 12/30/2003 through 03/30/2004
Order written by Edna Seals on 12/30/2003 at 0:25 AM.

Provider: JR Anderson

E Seals RN

Exhibit #___

ARKANSAS DEPARTMENT OF CORRECTION (REV. 07/93)

MEDICAL RESTRICTIONS/ LIMITATIONS/SPECIAL AUTHORIZATIONS

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RESTRICT INMATE FROM:

PART 1 RESTRICTIONS:

___ ASSIGNMENTS REQUIRING STRENUOUS PHYSICAL ACTIVITY FOR PERIODS IN EXCESS OF _____ HOURS.

___ ASSIGNMENT REQUIRING PROLONGED CRAWLING, STOOPING, RUNNING, JUMPING, WALKING OR STANDING.

___ ASSIGNMENT REQUIRING HANDLING/LIFTING OF HEAVY MATERIALS IN EXCESS OF _____ POUNDS OR REQUIRING OVERHEAD WORK FOR A PERIOD IN EXCESS OF _____ HOURS.

INMATE REQUIRES:

PART 2 LIMITATIONS:

*___ BED REST _____ DAYS REASON: _____

___ NO DUTY _____ DAYS REASON: _____

___ NO YARD CALL _____ DAYS REASON: _____

___ NO SPORTS _____ DAYS REASON: _____

___ ONE ARM/HAND DUTY _____ DAYS

INMATE IS AUTHORIZED TO:

PART 3 SPECIAL AUTHORIZATIONS:

___ REPORT TO THE INFIRMARY FOR SPECIAL TREATMENTS (_____ TIME)

___ SOAK: _____

___ EXERCISE: _____

___ OTHER: _____

___ BATHE IN THE INFIRMARY

___ SITZ BATH

___ CAST

___ OTHER: _____

___ HAVE IN POSSESSION:

___ CANE

___ CRUTCHES

___ BRACE: (DESCRIBE BRIEFLY) _____

___ PRESCRIBED FOOTWEAR: _____

___ ORTHOPEDIC APPLIANCE: (DESCRIBE BRIEFLY) _____

✓ OTHER: Allow to clip beard with clippers

*___ GO TO DINING/PILL WINDOW/SHOWER ONLY

THIS MEDICAL RESTRICTION(S)/LIMITATION(S)/SPECIAL AUTHORIZATION(S) STARTS: 4/13/04 (DATE) 1030h (TIME (MILITARY))

THIS MEDICAL RESTRICTION(S)/LIMITATION(S)/SPECIAL AUTHORIZATION(S) ENDS: 7/13/04 (DATE) 2300h (TIME (MILITARY))

_____
SIGNATURE OF MEDICAL STAFF

DISTRIBUTION:
ORIGINAL - MEDICAL JACKET
PINK - SECURITY
YELLOW - CLASSIFICATION
BLUE - INMATE

NAME: FENTY, D

DOB: _____

ADC#: 095976

Exhibit #

Arkansas Department of Correction
RESTRICTION/MEDICAL PASS ORDER

Inmate (Last Name, First Name, MI): **Felty, David L.** ADC #: **095976**
Facility: MAXIMUM SECURITY UNIT Site: MAX
Completed by: Lisa Anderson, LPN Encounter date: 1
0/08/2004

Restrictions

No shaving effective from 10/08/2004 through 01/08/2005 To keep beard clipped per ADC protocol
Order written by Lisa Anderson, LPN on 10/08/2004 at 8:40 AM.

Provider: Nnamdi Ifediora

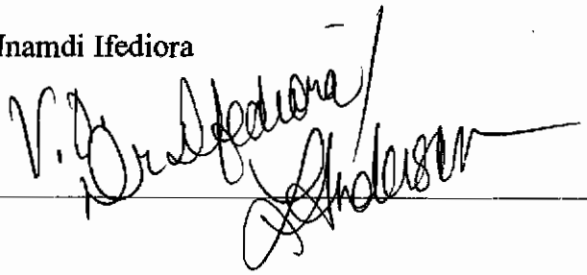


Exhibit #___

MSF - 207

Arkansas Department of Correction
Medical Restrictions/Limitations/Special Authorizations

Inmate (Last Name, First Name, MI): **Felty, David L.** ID#: **095976**
Facility: MAXIMUM SECURITY UNIT Site: MAX
Completed by: Encounter date: 01/20/2005

Restrictions

No shaving effective from 01/20/2005 through 06/30/2005
USE SHAVING CLIPPERS PER ADC PROTOCOL

Restrictions ordered by: Waseem Shah MD

Over: Witness Information →

Waseem Shah MD

 Exhibit #

ARKANSAS
DEPARTMENT OF CORRECTION (REV. 07/83)

MEDICAL RESTRICTIONS/
LIMITATIONS/SPECIAL AUTHORIZATIONS

MSF-2

RESTRICT INMATE FROM:

PART 1 RESTRICTIONS:

___ ASSIGNMENTS REQUIRING STRENUOUS PHYSICAL ACTIVITY FOR PERIODS IN EXCESS OF _____ HOURS.

___ ASSIGNMENT REQUIRING PROLONGED CRAWLING, STOOPING, RUNNING, JUMPING, WALKING OR STANDING.

___ ASSIGNMENT REQUIRING HANDLING/LIFTING OF HEAVY MATERIALS IN EXCESS OF _____ POUNDS OR REQUIRING OVERHEAD WORK FOR A PERIOD IN EXCESS OF _____ HOURS

INMATE REQUIRES:

PART 2 LIMITATIONS:

*___ BED REST ____ DAYS REASON: _____

___ NO DUTY ____ DAYS REASON: _____

___ NO YARD CALL ____ DAYS REASON: _____

___ NO SPORTS ____ DAYS REASON: _____

___ ONE ARM/HAND DUTY ____ DAYS

INMATE IS AUTHORIZED TO:

PART 3 SPECIAL AUTHORIZATIONS.

___ REPORT TO THE INFIRMARY FOR SPECIAL TREATMENTS (_____) TIME

___ SOAK: _____

___ EXERCISE: _____

___ OTHER: _____

___ BATHE IN THE INFIRMARY

___ SITZ BATH

___ CAST

___ OTHER: _____

___ HAVE IN POSSESSION:

___ CANE

___ CRUTCHES

___ BRACE: (DESCRIBE BRIEFLY) _____

___ PRESCRIBED FOOTWEAR: _____

___ ORTHOPEDIC APPLIANCE: (DESCRIBE BRIEFLY) _____

X OTHER: use clippers to shave

*___ GO TO DINING/PILL WINDOW/SHOWER ONLY

THIS MEDICAL RESTRICTION(S)/LIMITATION(S)/SPECIAL AUTHORIZATION(S) STARTS: 6-13-05 (DATE) 0900 (TIME-MILITARY)

THIS MEDICAL RESTRICTION(S)/LIMITATION(S)/SPECIAL AUTHORIZATION(S) ENDS: 6-13-06 (DATE) 2400 (TIME (MILITARY))

Mycales Rutf
SIGNATURE OF MEDICAL STAFF

DISTRIBUTION:
ORIGINAL - MEDICAL JACKET
PINK - SECURITY
YELLOW - CLASSIFICATION
BLUE - INMATE

NAME: FLETY, DAVID
ADC: 095976
RACE: W SEX: M DOB: 01/14/70

Exhibit #

ARKANSAS
DEPARTMENT OF CORRECTION (REV. 07/93)

MEDICAL RESTRICTIONS/
LIMITATIONS/SPECIAL AUTHORIZATIONS

MSF-207

RESTRICT INMATE FROM:

PART 1 RESTRICTIONS:

___ ASSIGNMENTS REQUIRING STRENUOUS PHYSICAL ACTIVITY FOR PERIODS IN EXCESS OF _____ HOURS.

___ ASSIGNMENT REQUIRING PROLONGED CRAWLING, STOOPING, RUNNING, JUMPING, WALKING OR STANDING.

___ ASSIGNMENT REQUIRING HANDLING/LIFTING OF HEAVY MATERIALS IN EXCESS OF _____ POUNDS OR REQUIRING OVERHEAD WORK FOR A PERIOD IN EXCESS OF _____ HOURS.

INMATE REQUIRES:

PART 2 LIMITATIONS:

*___ BED REST _____ DAYS REASON: _____

___ NO DUTY _____ DAYS REASON: _____

___ NO YARD CALL ____ DAYS REASON: _____

___ NO SPORTS ____ DAYS REASON: _____

___ ONE ARM/HAND DUTY ____ DAYS

INMATE IS AUTHORIZED TO:

PART 3 SPECIAL AUTHORIZATIONS:

___ REPORT TO THE INFIRMARY FOR SPECIAL TREATMENTS (_____)
TIME

___ SOAK: _____

___ EXERCISE: _____

___ OTHER: _____

___ BATHE IN THE INFIRMARY

___ SITZ BATH

___ CAST

___ OTHER: _____

___ HAVE IN POSSESSION:

___ CANE

___ CRUTCHES

X BRACE: (DESCRIBE BRIEFLY) Knee Brace

X PRESCRIBED FOOTWEAR: Athletic shoes

X ORTHOPEDIC APPLIANCE: (DESCRIBE BRIEFLY) _____

___ OTHER: Clipper shave to 1/2" guard

*___ GO TO DINING/PILL WINDOW/SHOWER ONLY

THIS MEDICAL RESTRICTION(S)/LIMITATION(S)/SPECIAL AUTHORIZATION(S) STARTS: 3/19/2007 (DATE) 10:00 AM (TIME MILITARY)

THIS MEDICAL RESTRICTION(S)/LIMITATION(S)/SPECIAL AUTHORIZATION(S) ENDS: 3/19/2008 (DATE) 10:00 AM (TIME MILITARY)

SIGNATURE OF MEDICAL STAFF

DISTRIBUTION:
ORIGINAL - MEDICAL JACKET
PINK - SECURITY
YELLOW - CLASSIFICATION
BLUE - INMATE

Name: Felty, David L.
ADC# 095976
DOB: 01/14/70
W/M

Exhibit H

#16666

INFORMAL RESOLUTION FORM (Attachment 1)

UNIT/CENTER Tucker Max

PLEASE PRINT
Name David Felty ADC# 95976 ~~Brks~~ ~~Job Assignment~~ East #8 Isolation

IS THIS AN EMERGENCY SITUATION? YES ___ NO ✓ If yes, why? _____

(An emergency situation is one in which you may be subject to a substantial risk or physical harm. It should not be declared for ordinary problems that are not of a serious nature.) If you marked yes, you may give this completed form to the designated problem-solving staff, who will sign the attached emergency receipt. You will be given a copy of this receipt by the designated problem-solving staff. REPRISALS: If you are harmed or threatened because of your use of the grievance form, report it immediately to the Warden.

Give a **BRIEF** statement of your complaint/concern. This statement must be specific as to the complaint, **dates**, places, personnel involved and how **you** were affected. **One issue** or incident per complaint form. Additional pages or forms will **not** be allowed.

I went to classification today on August 4, 2004 and was harrassed about my having hair on my face by Lt. Bailey. I informed him I have a valid shaving with clippers script and that I am not being given daily access to the clippers in punitive, nor while assigned to Ad-Seg and policy requires A clean shave, also I want to be clean shaven inside grooming policy is. He stated that policy says they will get to me when they get time and that will be every other weekend. He informed me till then to use a razor. I advised him I had no problem doing that in the area's I do not have a medical problem in but the other part would have to be cut by clippers he said use A razor or I will start writing you up keep it clean I dont care what medical says.

~~David Felty~~ #95976
Inmate Signature

August 4, 2004
Date

THIS SECTION TO BE FILLED OUT BY STAFF ONLY.

STAFF RECEIPT AND ACTION TAKEN

C/O F. Lakeberry _____ Sgt Mathews 8/4/04
PRINT STAFF NAME (PROBLEM SOLVER) Staff Code Staff Signature / Date Received

Was this deemed an emergency? Yes ___ No ✓

Was there a need to contact medical? Yes ___ No ✓ If yes, give name of person contacted? _____

Describe action taken to resolve complaint, including dates. This is rejected due to the fact you did not follow policy + procedures. See AD-9708 you can only write in the space provided. When you write outside the space provided this causes for automatic rejection. Rejected!!

Was issue resolved? Yes ___ No ✓ Does inmate agree that issue was resolved? Yes ___ No ___

C/O ~~[illegible]~~ 8/13/04
Staff Signature/Date

I/M not in cell 8:42pm
Inmate Signature/Date

8/13/04

DISTRIBUTION: YELLOW – Inmate Receipt

(AFTER COMPLETION) PINK – Problem Solver Copy **BLUE** – Grievance Officer

ORIGINAL – Given back to the Inmate After Completion

810-00

Exhibit # #1668

INFORMAL RESOLUTION FORM (Attachment 1)

UNIT/CENTER Tucker Max East #8 Isolation

PLEASE PRINT

Name DAVID FELTY ADC# 95976 ~~Brks~~ ___ ~~Job Assignment~~ ___

IS THIS AN EMERGENCY SITUATION? YES ___ NO ✓ If yes, why? ___

(An emergency situation is one in which you may be subject to a substantial risk or physical harm. It should not be declared for ordinary problems that are not of a serious nature.) If you marked yes, you may give this completed form to the designated problem-solving staff, who will sign the attached emergency receipt. You will be given a copy of this receipt by the designated problem-solving staff. REPRISALS: If you are harmed or threatened because of your use of the grievance form, report it immediately to the Warden.

Give a **BRIEF** statement of your complaint/concern. This statement must be specific as to the complaint, **dates**, places, personnel involved and how **you** were affected. **One issue** or incident per complaint form. Additional pages or forms will **not** be allowed.

It has been three yrs since ive had my teeth cleaned each time I get to the top of the cleaning list I get transfered. Ive been on the cleaning list here over A year now And have not had my appointment.

I was transfered here on July 3, 2003 it is now August 3, 2004.

I placed in my request/sick call in July 2003.

David ~~Felty~~ #95976
Inmate Signature

August 3, 2004
Date

THIS SECTION TO BE FILLED OUT BY STAFF ONLY.

STAFF RECEIPT AND ACTION TAKEN

CO2 T. Rasberry ___ Sgt Matthews 8-4-04

PRINT STAFF NAME (PROBLEM SOLVER) Staff Code Staff Signature / Date Received

Was this deemed an emergency? Yes ___ No ✓

Was there a need to contact medical? Yes ✓ No ___ If yes, give name of person contacted? Dr. Carpenter (Dentist)

Describe action taken to resolve complaint, including dates Dental records reflect that have received only one SCL for cleaning dated 3/18/04 from Inmate Felty D. you are on the cleaning list as of that date to see the dental hygienist when your page comes up. No patient is placed before others unless they are found to have periodontal disease severe enough to have an effect on their health.

Was issue resolved? Yes ✓ No ___ Does inmate agree that issue was resolved? Yes ___ No ___

CO2 T. 8/13/04. I'm not in cell 8:42pm

Staff Signature/Date Inmate Signature/Date

DISTRIBUTION: YELLOW – Inmate Receipt

(AFTER COMPLETION) PINK – Problem Solver Copy BLUE – Grievance Officer AD 8/13/04

ORIGINAL – Given back to the Inmate After Completion

810-00

hydrase. Formerly used as a diuretic, and now used in the treatment of *high altitude pulmonary edema* and glaucoma.

ACETONE N. colorless liquid with a characteristic sweet, fruity odor present in small amounts in normal urine but in increased amounts in the blood and urine of persons with faulty glucose and fat metabolism (e.g., in *diabetes mellitus* and certain other metabolic disorders). Commercially available specially treated paper and sticks that turn a certain color when wet with urine containing acetone are used by some persons with diabetes mellitus to test for acetone production as an indication of the course of their disorder.

ACETONE BODIES see **ketone bodies.**

ACETONEMIA N. presence of large amounts of *acetone* in the blood.

ACETONURIA see **ketonuria.**

ACETYLCHOLINE N. chemical that is an important *neurotransmitter* in the body, functioning in the transmission of impulses between nerve cells and between nerve cells and muscle.

ACETYLSALICYLIC ACID see **aspirin.**

ACHALASIA N. failure of a muscle, particularly a sphincter (muscular ring or valve), to relax, esp. in the gastrointestinal tract (e.g., the cardiac sphincter of the stomach) (see also **cardiospasm**).

ACHE N. a dull, usually moderately intense, persistent pain as in *headache.*

ACHILLES TENDON N. large *tendon* that connects the calf muscles to the heelbone.

ACHLORHYDRIA N. abnormal condition characterized by the absence of *hydrochloric acid* in the *gastric juice*, often associated with *pernicious anemia*, other severe anemias, and cancer of the stomach. ADJ. **achlorhydric**

ACHOLIA N. 1. condition in which little or no *bile* is secreted. 2. condition in which the normal flow of bile into the digestive tract is obstructed.

ACHONDROPLASIA N. inherited disorder in which a defect in cartilage and bone formation results in a form of *dwarfism* characterized by short limbs on a normal trunk; also called **chondrodystrophy.** ADJ. **achondroplastic**

ACHROMASIA N. condition in which there is less pigment in the skin than is normal; pallor (see also **albinism**; **vitiligo**).

ACHROMATISM N. state of seeing gray tones instead of colors; colorlessness.

ACHROMIA N. absence of normal color, as in *albinism.* ADJ. **achromic**

ACHROMYCIN N. trade name for the antibiotic *tetracycline.*

ACHYLIA N. absence or severe deficiency of *hydrochloric acid*, *pepsinogen*, or other digestive secretions. ADJ. **achylous**

ACID N. 1. chemical that has at least one hydrogen atom, tastes sour, turns litmus paper pink or red, and forms a salt when combined with a *base* (*hydrochloric acid* is normally a part of the digestive juice produced in the stomach). 2. colloquialism for *lysergic acid diethylamide* (LSD), a drug that causes *hallucinations* (a person using LSD is called an "acid head"). ADJ. **acidic**

ACID-BASE BALANCE N. normal equilibrium between *acids* and alkalis (*bases*) in the body maintained by buffer systems in the blood and the regulatory activities of the lungs and kidneys in excreting wastes to prevent the buildup of excessive acids (*acidosis*) or alkalis (*alkalosis*) in the blood and other tissues. With a normal acid-base balance in the body, the blood is slightly alkaline, registering 7.35–7.45 on the *pH* scale (where 7 is neutral and above 7 alkaline).

ACIDEMIA N. condition in which there is an increased concentration of hydrogen ions in the blood and hence the blood is more acid than normal (below 7 on the *pH* scale.)

ACID-FAST ADJ. pert. to microorganisms whose stained color resists decolorization after treatment with an acid solution, esp. the tubercle bacillus *Mycobacterium tuberculosis.*

ACIDITY N. condition of having an acid content, or of being an acid, or of tasting sour.

ACIDOPHIL N. 1. cell that readily stains with acids. 2. microorganism that grows in acidic materials; also called **acidophile.** ADJ. **acidophilic**

ACIDOPHILUS MILK N. preparation of milk that has been acted on (fermented) by a bacterium (*Lactobacillus acidophilus*), used in treating some intestinal disorders.

ACIDOSIS N. disturbance in the normal *acid-base balance* of the body in which the blood and body tissues are more acidic than normal. It may result from respiratory causes leading to retention of carbon dioxide, as in breathing disorders; from metabolic causes such as prolonged or severe diarrhea, from impaired kidney function, as a complication of diabetes, or as a result of several common poisonings (salicylate, cyanide, isoniazide, methanol).

ACID POISONING N. poisoning resulting from the ingestion of a toxic acidic compound, such as hydrochloric acid, sulfuric acid, or nitric acid, many of which are found in cleaning products; for emergency treatment, contact a local poison control center for advice.

ACINIFORM ADJ. grape-shaped, as some tumors.

ACINUS N. general term for a small saclike structure, esp. that found in a gland. pl. **acini**, ADJ. **acinar, acinic, acinose, acinous**

ACNE N. inflammatory disease of the *sebaceous glands* of the skin, usually on the face and upper body, characterized by papules, pustules, comedones (blackheads) and in severe cases by cysts, nodules, and scarring. The most common form—**acne vulgaris**—usually affects persons from puberty to young adulthood. Treatment includes topical and oral antibiotics (e.g., tetracycline—but not before age 12), topical vitamin A derivatives, *dermabrasion*, and *cryosurgery.* (See also **rosacea.**)

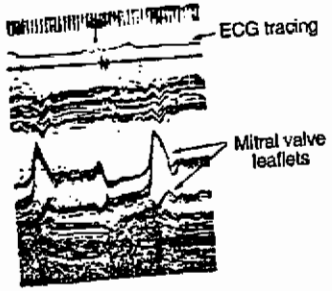
ACNEIFORM ADJ. resembling or like acne.

ACNE ROSACEA see **rosacea.**

ECHINOCOCCOSIS N. infection with a larval tapeworm (*Echinococcus*), usually transmitted through contact with infected dogs (esp. their stool). It is characterized by cyst formation in tissue, esp. the liver; symptoms depend on the tissue affected. Treatment involves surgical excision of the cysts. Also called **hydatid disease.**

ECHOCARDIOGRAPHY N. diagnostic procedure using ultrasound waves to study the heart, its structure and motions. It is used to assess disorders of cardiac muscle function or valve function, or other abnormalities.

TYPICAL M-MODE ECHOCARDIOGRAM OF THE MITRAL VALVE



ECHOENCEPHALOGRAPHY N. diagnostic procedure using ultrasound waves to study the brain; it may reveal expanding lesions or expansion of brain ventricles.

ECHOLALIA N. in psychiatry, automatic and meaningless repetition of another's words, sometimes occurring in *schizophrenia* and other neurological and mental disorders.

ECHO VIRUS N. any of a group of small viruses, some of which are responsible for human illnesses.

ECLAMPSIA N. rare (approx. 0.2% of all pregnancies in the United States) and serious pregnancy disorder. Eclampsia is characterized by convulsions, coma, high blood pressure, protein in the urine, and edema; signs of impending convulsions include headache, blurred vision, epigastric pain, and anxiety. Once the convulsions are controlled and emergency treatment of the pregnant woman is completed, delivery of the fetus is usually necessary (fetal mortality is 25%). (See also **toxemia of pregnancy.**) ADJ. **eclamptic**

ECSTASY N. emotional state marked by exalted delight, exhilaration, extreme joy. ADJ. **ecstatic**

ECT see **electroconvulsive therapy.**

ECTASIA N. dilatation or distension of a part or organ (e.g., **alveolar ectasia**, abnormal expansion of the air sacs in the lungs); also **ectasis** (compare *atelectasis*).

ECTO- comb. form meaning "outer," "outside," (e.g., **ectogenous**, coming from the outside, as disease-causing germs) (compare *endo-*).

ECTODERM N. in the embryo, outside layer of cells from which the nervous system, skin, special sense organs (eyes, ears), and certain other body parts arise. (The two other cell layers are the inner *endoderm* and the middle *mesoderm.*) ADJ. **ectodermal, ectodermic**

ECTOMORPH N. person whose physique is thin, fragile, and generally nonmuscular (compare *endomorph*; *mesomorph*). ADJ. **ectomorphic**

-ECTOMY suffix indicating surgical removal of a part or organ (e.g. **appendectomy**, removal of the appendix).

ECTOPIA N. abnormal positioning of a part or organ, esp. at the time of birth. ADJ. **ectopic**

ECTOPIC PREGNANCY N. abnormal pregnancy, occurring in about 2% of all pregnancies, in which the fertilized egg (conceptus, embryo) implants outside of the uterus, most often (90%) in the Fallopian tube (*tubal pregnancy*) but occasionally in the ovary (ovarian pregnancy) or abdominal cavity (*abdominal pregnancy*). As the embryo develops the tube ruptures or other complications arise, usually causing hemorrhage and requiring immediate surgery. Also called **extrauterine pregnancy.**

ECTRO- comb. form indicating *congenital* absence (e.g., **ectromelia**, congenital absence or marked shortening of the long bones of one or more limbs).

ECTRODACTYLY N. *congenital* absence of some fingers or toes.

ECTROGENY N. *congenital* absence of any body part or organ.

ECTROPION N. turning outward (eversion) of an edge or margin, esp. of the eyelid, as a result of injury, facial nerve paralysis, or atrophy of eye tissues.

ECZEMA N. inflammation of the skin that usually produces itching and the development of small blisterlike formations that release fluid and then form scales. It may be caused by contact with a specific irritant or occur without apparent cause. Treatment usually involves topical corticosteroids. ADJ. **eczematous**

EDECRIN N. trade name for the diuretic *ethacrynic acid.*

EDEMA N. abnormal collection of fluid in spaces between cells, esp. just under the skin or in a given cavity (e.g., peritoneal cavity) or organ (e.g., the lungs—*pulmonary edema*). Causes include injury, heart disease, kidney failure, *cirrhosis*, and *allergy*. Treatment depends on the cause but often involves bedrest, *diuretics*, and restriction of salt. Formerly known as **dropsy**; also called **hydrops.** ADJ. **edematous**

EDENTULOUS ADJ. without teeth, as when all the natural teeth have been removed.

EEG see **electroencephalogram.**

EES see **erythromycin.**

EFFACEMENT N. shortening of the *cervix* and thinning of its walls as it is stretched and dilated during *labor.*

EFFERENT ADJ. carrying outward, away from the center, as a nerve carrying impulses from the brain to a muscle, gland, or other effector organ, or as a vessel (e.g., a blood or lymphatic vessel) carrying fluid (e.g., blood, lymph) away from an organ or part (compare *afferent*).

EFFLEURAGE N. rhythmic, firm or gentle, stroking, as in massage. Effleurage of the abdomen is commonly used in the *Lamaze method of childbirth.*

EFFUSION N. escape of fluid (e.g., blood, lymph, serum)

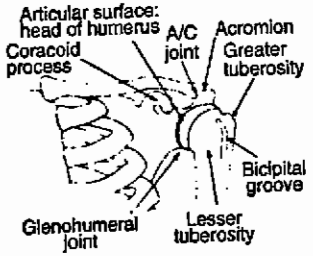
blood pressure, though classically associated with shock, is a late sign, especially in children. Treatment is primarily that of the underlying condition. Intravenous fluid therapy helps most patients, at least initially.

SHOCK THERAPY see **electroconvulsive therapy.**

SHORT-ACTING ADJ. pert. to a drug or other agent that has a short period of effectiveness, usually beginning shortly after administration (compare *long-acting*).

SHOULDER BLADE see **scapula.**

SHOULDER



SHOULDER JOINT N. *ball-and-socket joint* in which the *humerus* articulates with the *scapula.*

SHUNT V. to redirect the flow of a body fluid from one vessel to another. N. device implanted to redirect the flow of a body fluid.

Si symbol for the element *silicon.*

SIAL-, SIALO- comb. forms indicating an association with *saliva* or the *salivary glands* (e.g., **sialadenitis,** inflammation of the salivary glands).

SIALOLITH N. stone formed in a *salivary gland.*

SIAMESE TWINS N. twins born joined together at one or more body parts and often sharing a body part. Most Siamese twins can be separated surgically, the prognosis depending on the site of connection and the extent of shared organs. Also called **conjoined twins.**

SIBLING N. one of two or more children who have both parents in common.

SICKLE CELL N. abnormal red blood cell (*erythrocyte*) with a crescent shape and abnormal form of *hemoglobin.*

SICKLE-CELL ANEMIA N. hereditary blood disease, occurring mostly in blacks, in which abnormal *hemoglobin* (hemoglobin HbS) causes red blood cells (*erythrocytes*) to become sickle-shaped, fragile, and nonfunctional, leading to anemia. Persons inheriting the trait from only one parent may show few symptoms; those homozygous for the trait (inheriting it from both parents) have chronic anemia, an enlarged spleen, lethargy, weakness, blood clot formation, and joint pain.

SICKLE-CELL TRAIT N. heterozygous *sickle-cell anemia* with both normal and abnormal *hemoglobin* present. There are usually few or no symptoms, the main concern being possible transmission to offspring. (See also **sickle-cell anemia.**)

SIDEROPENIA N. iron deficiency, caused by inadequate iron intake in the diet or increased loss from the body, as occurs in hemorrhage or chronic bleeding. The major manifestation is anemia, corrected by iron administration.

SIDEROSIS N. form of *pneumoconiosis* in which iron dust or particles affect the lungs, causing *fibrosis*; it occurs among welders and other metal workers.

SIDS see **sudden infant death syndrome.**

SIGMOID COLON N. that part of the colon extending from the end of the descending colon to the rectum.

SIGMOIDECTOMY N. surgical removal of all or part of the *sigmoid colon*, usually to remove a malignant tumor.

SIGMOIDOSCOPE N. instrument, consisting of a tube and light, inserted through the anus to allow visualization of the *sigmoid colon.*

SIGN N. observable indication of a disease (e.g., *Babinski reflex*) (compare *symptom*).

SILICON N. nonmetallic element; occurs in traces in bones and teeth (see also Table of Important Elements).

SILICOSIS N. form of *pneumoconiosis* produced by inhaling silica dust; common among sandblasters, some miners, and others who work with sand.

SILVER NITRATE N. topical anti-infective agent used on wound dressings and placed in the eyes of newborns to prevent infection.

SIMPLE FRACTURE see **fracture.**

SIMPLE MASTECTOMY see **mastectomy.**

SIMVASTATIN N. oral agent (trade name **Zocor**) used in the treatment of *hypercholesterolemia*; the most common side effects are gastrointestinal disturbance (e.g., constipation).

SINEQUAN N. trade name for the antidepressant *doxepin.*

SINEW see **tendon.**

SINGULTUS see **hiccup.**

SINISTRALITY see **left-handedness.**

SINOATRIAL NODE (SA NODE) N. area of modified cardiac muscle in the right atrium near the entry of the superior *vena cava* that generates impulses that travel through the muscles of both atria, causing them to contract. Cells in the node have an intrinsic rhythm independent of nerve impulse stimulation. Normally the node fires about 60–80 beats per minute, with certain hormones and other factors (e.g., exercise) causing faster rate. An artificial pacemaker can be used in cases of defective sinoatrial node. Also called **pacemaker.** (Compare *antrioventricular node.*)

SINUS N. 1. air cavity within a bone, esp. the *paranasal sinuses* in the bones of the face and skull. 2. wide channel containing blood (e.g., *venous sinuses* in the dura mater, draining blood from the brain).

SINUS HEADACHE N. pain in the head resulting from congestion and/or infection in the *paranasal sinuses.* Typically the discomfort is localized over the forehead or behind the eyes and is increased by bending over. Treatment involves *decongestants, analgesics,* and sometimes *antibiotics.*

SINUSITIS N. inflammation of one of the *paranasal sinuses* occurring as a result of an upper respiratory infection, an allergic response, a change in atmospheric pressure, or a defect of the nose. As sinus secretions

Exhibit #

Submandibular Gland Stones & Ludwig's Angina

Pictures

Acute Parotitis

Neck Abscess

Submandibular gland excision

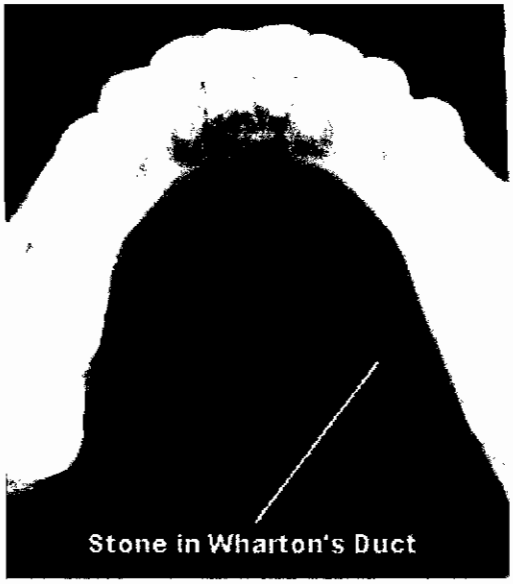
Submandibular pleomorphic adenoma

Submandibular Lipoma

LUDWIG'S ANGINA is an inflammation of the submandibular space, usually starting in the submaxillary space and spreading to the sublingual space via the fascial planes, not the lymphatics. As the submandibular space is expanded by cellulitis or abscess formation, the floor of the mouth becomes indurated and the tongue is forced upward and backward, causing airway obstruction. Ludwig's angina does not necessarily mature to form an abscess, it is more likely to produce a cellulitis or a phlegmon. It is typically bilateral and presents with drooling, trismus, pain, dysphagia, submandibular swelling airway obstruction caused by displacement of the tongue. The tongue may protrude outside the mouth. This is a life-threatening condition that requires tracheotomy. Before antibiotics, the mortality rate of Ludwig's angina was 50%. With modern antimicrobial and surgical therapies, the mortality rate is less than 5%.

Search

Ludwig's Angina requiring a tracheotomy and drainage. Click picture to enlarge.



This patient developed acute upper respiratory obstruction. The swelling became so severe that the tongue protruded outside the mouth. A tracheotomy was performed to provide an airway. After resolution of the infection, a large stone was found in the submandibular gland duct (Wharton's duct). The radio-opacity in the occlusal film on the left rapresents the stone that was removed (see picture below)

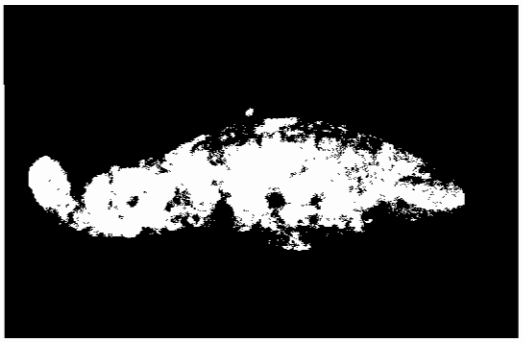


Exhibit #

EXCISION OF SUBMANDIBULAR GLAND

Submandibular sialadenectomy (excision of submandibular gland) is indicated for various conditions, ranging from chronic infection to tumors. The submandibular gland has a higher incidence of malignant tumors than the parotid gland (about 2/3 of tumors are malignant versus 1/5 in the parotid) Stones may form in the duct or inside the substance of the gland, causing it to swell. The marginal mandibular branch of the facial nerve runs just lateral to the gland and is carefully localized prior to removing the gland.

Pleomorphic adenoma of the right submandibular gland. The facial nerve stimulator grounding electrode is seen in the right lower aspect of the incision.

Pictures

Submandibular Lipoma

Submandibular Pleomorphic Adenoma

Pleomorphic Adenomas of Salivary Glands

Submandibular Stones and Infections

Ludwig's Angina

Parotidectomy

Neck Masses

Neck Incision

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This page was last updated on: September 26, 2004

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Exhibit #

IISO100 STATUS ASSIGNMENT SHEET TIME 10:10

ADC NO: 095976A NAME: FELTY, DAVID L. ("A") STATUS: ACTIVE ADC
DD: 04/18/2013 PE: 07/18/2004 CL: I-C MED.: M2

		SEE COMMENTS				
02/24/00	DR	USE OF DRUGS, ALCOHOL, CHEMI	G	GT CLASS REDUCED		IV
		SEE COMMENTS		ISOLATION DAYS		030
				TIME FORFEIT DAY		0365
06/22/00	DR	INSOLENCE TO A STAFF MEMBER	G	GT CLASS REDUCED		IV
		USING ABUSIVE/OBSCENE LANGUA	G	ISOLATION DAYS		030
		FAILURE TO OBEY ORDER OF STA	G			
03/02/01	DR	FAILURE TO OBEY ORDER OF STA	G	GT CLASS REDUCED		IV
		POSSESSION OF CLOTHING	G	ISOLATION DAYS		030
		TAKING OF PROPERTY	G	TIME FORFEIT DAY		0090
06/29/01	DR	FAILURE TO OBEY ORDER OF STA	G	GT CLASS REDUCED		IV
				ISOLATION DAYS		010
10/24/01	MV	TRANSFERRED TO			NORTH CENTRAL U	
10/24/01	MV	RECEIVED FROM			CUMMINS UNIT	
11/09/01	DR	FAILURE TO OBEY ORDER OF STA	G	GT CLASS REDUCED		III
				TIME FORFEIT DAY		0060
11/26/01	DR	BATTERY	G	GT CLASS REDUCED		IV
		SEE COMMENTS		ISOLATION DAYS		020
				TIME FORFEIT DAY		0090
12/18/01	DR	INTERFERING WITH COUNT	G	ISOLATION DAYS		010
		INSOLENCE TO A STAFF MEMBER	G			
		USING ABUSIVE/OBSCENE LANGUA	G			
03/06/02	DR	INSOLENCE TO A STAFF MEMBER	G	ISOLATION DAYS		020
		SEE COMMENTS		TIME FORFEIT DAY		0090
05/30/02	DR	FAILURE TO OBEY ORDER OF STA	G	ISOLATION DAYS		015
		SEE COMMENTS				
		ASSAULT	G	GT CLASS REDUCED		IV
		USING ABUSIVE/OBSCENE LANGUA	G	ISOLATION DAYS		020
		SEE COMMENTS				
06/03/02	DR	ASSAULT	G	GT CLASS REDUCED		IV
		INSOLENCE TO A STAFF MEMBER	G	ISOLATION DAYS		030
		USING ABUSIVE/OBSCENE LANGUA	G	TIME FORFEIT DAY		0150
		FAILURE TO OBEY ORDER OF STA	G			
		SEE COMMENTS				
06/04/02	DR	WRITTEN THREATS OF BODILY HA	G	ISOLATION DAYS		030
		SEE COMMENTS		TIME FORFEIT DAY		0150
09/03/02	DR	FAILURE TO OBEY ORDER OF STA	G	ISOLATION DAYS		020
		MALINGERING, FEIGNING ILLNES	G	TIME FORFEIT DAY		0090
		SEE COMMENTS				
10/04/02	MV	TRANSFERRED TO			GRIMES UNIT	
10/04/02	MV	RECEIVED FROM			NORTH CENTRAL UNIT	
04/16/03	MV	OUT TO HOSPITAL			DIAGNOSTIC HOSP	
04/16/03	MV	RET. FM. HOSP.	MEDICAL NEEDS		DIAGNOSTIC HOSP	
04/17/03	MV	TRANSFERRED TO	IMPROVED HEALTH		GRIMES UNIT	
04/17/03	MV	RECEIVED FROM	IMPROVED HEALTH		DIAGNOSTIC HOSPITA	

FELTY, DAVID 5032229
OUTPATIENT 033Y/M/C
MR#: 0000153649 DR: BURNETT, HUG
DOB: 01/14/1970 ADM: 04/16/2003
SOURCE:

Exhibit 4

Exhibit # 56 of 61

INFORMAL RESOLUTION FORM (Attachment 1)

RECEIVED

SEP 0 6 2005

GRIEVANCE OFFICER

MX05 1339

UNIT/CENTER Tucker Max

PLEASE PRINT

Name David Felty MAXIMUM SECURITY UNIT Bnks ___ East Isolation # 10 Cell Job Assignment ___

IS THIS AN EMERGENCY SITUATION? YES ✓ NO ___ If yes, why? I cannot get proper medical knee and footwear till proper diagnosis can be made from x-ray of patella.

(An emergency situation is one in which you may be subject to a substantial risk or physical harm. It should not be declared for ordinary problems that are not of a serious nature.) If you marked yes, you may give this completed form to the designated problem-solving staff, who will sign the attached emergency receipt. You will be given a copy of this receipt by the designated problem-solving staff. REPRISALS: If you are harmed or threatened because of your use of the grievance form, report it immediately to the Warden.

Give a **BRIEF** statement of your complaint/concern. This statement must be specific as to the complaint, **dates**, places, personnel involved and how **you** were affected. **One issue** or incident per complaint form. Additional pages or forms will **not** be allowed.

On 8/13/05 I requested to have a full review access review of my medical file dating from 1991 to 2005 to Infirmary Records and to Ms. Green. On 8/24/05 these records were not in full. On reviewing of my medical file. On 8/24/05 I requested to review file again with the same info to the same staff. On today's date 8/30/05 I note that this info is still not there nor is the info I ask for on request for interview to the above personal on specific x-rays, namely two of the four occlusals being returned to my medical file that were made on 5/26/05 and sent to Dr. Burnett but never returned to my file. I'm also requested new x-rays of my patella bone due to the 9/21/04 Radiology Report. My injury is to the patella it's apparent this is the x-ray most needed for Consult.

David Felty
Inmate Signature

RECEIVED OFFICE OF THE INVESTIGATOR GENERAL SEP 07 2005 ARKANSAS DEPARTMENT OF CORRECTION CENTRAL PROCESS SECTION

8/30/05
Date

THIS SECTION TO BE FILLED OUT BY STAFF ONLY.

STAFF RECEIPT AND ACTION TAKEN

___ ___ Sgt Bubba 8-31-05

PRINT STAFF NAME (PROBLEM SOLVER) Staff Code Staff Signature / Date Received

Was this deemed an emergency? Yes ___ No ___

Was there a need to contact medical? Yes ___ No ___ If yes, give name of person contacted? ___

Describe action taken to resolve complaint, including dates. After reviewing your medical jacket I found the report regarding your 4 occlusal X-ray's & the Virus are kept at Dr. Burnett's office at this time. If you need assistance viewing your ~~med.~~ medical jacket review please ASK for help

Was issue resolved? Yes ___ No ✓ Does inmate agree that issue was resolved? Yes ___ No ✓

Sgt. Gurley 9/2/05
Staff Signature/Date

David Felty 9/2/05
Inmate Signature/Date

DISTRIBUTION: YELLOW – Inmate Receipt

(AFTER COMPLETION) PINK – Problem Solver Copy **BLUE** – Grievance Officer

ORIGINAL – Given back to the Inmate After Completion

810-00

Exhibit #

GRIEVANCE FORM - (Attachment 1A)

RECEIVED
SEP 06 2005
GREIVENCE OFFICER
MAXIMUM SECURITY UNIT

FOR OFFICE USE ONLY
Grv. # MX05 1339
Date Received 9.6.05
Grievance Code: 600

UNIT/CENTER Tucker Max

PLEASE PRINT
Name David Felty ADC# 95976 Brks East Isolation #10 Cell Job Assignment

IS THIS GRIEVANCE A MEDICAL GRIEVANCE? Yes ✓ No ___

All complaints/concerns should first be handled informally before proceeding to the formal grievance procedure.

THE ORIGINAL INFORMAL RESOLUTION FORM SHALL BE ATTACHED

Informal Action Taken

Have you discussed this problem with your designated problem-solver? Yes ✓ No ___ If yes, give date 9/2/05

Why do you feel the informal resolution was unsuccessful? There is no mention that the two occlusals at Dr. Burnett's office are per policy being placed back in my file, no mention of the 1991-2005 file access, no mention of why x-ray on patella is not being performed, all in violation of medical policy's.

Please give a **BRIEF**, clear statement of your grievance. This statement must be specific as to the complaint, **dates**, places, personnel involved, how **you** were affected and what you want to resolve the issue. **One issue** or incident per grievance. Additional pages or forms will **not** be allowed and if attached, will result in the automatic rejection of this grievance without content review.

On 8/13/05 I requested to have a full review access review of my medical file dating from 1991 to 2005 to Infirmary Records and to Ms. Green. On 8/24/05 these records were not in full. On reviewing of my medical file. On 8/24/05 I requested to review file again with the same info to the same staff. On todays date 8/30/05 I note that this info is still not there nor is the info I ask for on request for interview to the above personal on specific x-rays, namely two of the four occlusals being returned to my medical file that were made on 5/26/05 and sent to Dr. Burnett but never returned to my file. Im also requesting new x-rays of my patella bone due to the 9/21/04 Radiology Report. My injury is to the patella it's apparent this is the x-ray most needed for Consult.

IS THIS AN EMERGENCY SITUATION? YES ✓ NO ___ If yes, why? I cannot get proper medical attention and diagnosis.

(An emergency situation is one in which you may be subject to a substantial risk or physical harm. It should not be declared for ordinary problems that are not of a serious nature.) If you marked yes, you may give this completed form to any officer or department employee who shall sign the attached emergency receipt, give you the receipt and deliver it without undue delay to the ARO, the Warden/Center Supervisor or, in their absence, to the Unit/Center Assistant Warden. REPRISALS: If you are harmed or threatened because of your use of the grievance form, report it immediately to the Warden.

#95976 9/2/05
INMATE SIGNATURE **DATE**

OFFICE OF INVESTIGATIONS OCT 07 2005 ARKANSAS DEPT. OF CORRECTION

(TO BE FILLED OUT BY THE RECEIVING OFFICER)

RECEIPT FOR EMERGENCY SITUATIONS

OFFICER (Please Print) Betty J. Thomas Signature Co II Thomas

FROM WHICH INMATE? Felty ADC# 95976

DATE: 9-2-05 TIME: 3:10 pm

Exhibit #4

CMS GRIEVANCE RESPONSE

Grievance #: MX#05-01339

Inmate: Felty, David	**ADC# 095976**	**DOB:**
Facility: Maximum Security Unit	**Barracks:** E-10	
Ltr Date 09/02/05	**Date Infirmary Rec'd:** 09/08/05	**Response Date:** 09/08/05

Interview: X **Required** 8/11/05	**Deferred**

Inmate's Complaints: (Code 603) On 8/13/05 I requested to have a full review access review of my medical file dating from 1991 to 2005 to infirmary records and to Ms. Green. On 8/24/05 these records were not in full. On reviewing my medical file. On 8/24/05 I requested to review file again with the same info to the same staff. On today's date 8/30/05 I note that this info is still not there nor is the info I ask for on request for interview to the above personnel on specific x-rays, namely two of the four occlusals being returned to my medical file that were made on 5/26/05 and sent to Dr. Barnett but never returned to my file. I also am requesting new xrays of my patella bone due to the 9/21/04 radiology report. My injury is to the patella its apparent this is the xray most needed for consult.

Response: *You request that the two occlusion x-rays be returned to your medical jacket; we will contact Dr. Burnett and request that the x-rays be returned to your jacket at his earliest convenience. If he has completed his process with them. Your medical jacket is complete in medical; you reviewed it last on August 30, 2005. The xray of your patella is a year old; at no time in the last year have you placed a sick call in reference to your knee. If you are continuing to have trouble with your knee please place a sick call and follow the sick call process. If I can be of further assistance feel free to contact me.*

Recommendation: Please use the sick call process for your medical concerns.

Responding Staff **Juanita Stell LPN** **Date 09/08/05**

Original - ADC Grievance Officer
Copy - Inmate
Copy - File

Follow Up Required? No x Yes Date

ATTACHMENT VII

Exhibit #

Attachment II

INMATE NAME FELTY, D ADC# 095976 GRIEVANCE# MX#05-01339

WARDEN'S/CENTER SUPERVISOR'S DECISION

I have determined that your grievance is a medical matter. I have forwarded your grievance to the Medical Administrator who will provide a written response, and/or will interview you within twenty working days of the date I received your grievance. Should you receive no response within this time frame, or the response that you received is unsatisfactory, you may appeal to the Deputy Director for Health and Correctional Programs. If you have medical needs that you believe are urgent, put in a Sick Call Request, or send a Request for an Interview to the Medical Administrator.

*

Signature of ARO or Warden's/Supervisor's Designee	WARDEN Title	9-6-05 Date

INMATE'S APPEAL

If you are not satisfied with this response, you may appeal this decision within five days by filling in the information requested below and mailing it to the appropriate Deputy/Assistant Director. Keep in mind that you are appealing the decision to the original complaint. Do not additional issues which are not a part of your complaint.

WHY DO YOU NOT AGREE WITH THE RESPONSE?

X-rays of my patella have not been done neither have the occlusal X-rays sent to Dr. Burnett been returned to my files.

RECEIVED OFFICE OF THE INVESTIGATOR OCT 07 2005 HEALTH & CORRECTIONAL SERVICES AR DEPT. OF CORRECTIONS

Inmate Signature	ADC# 095976	Sept 10, 2005 Date

Attachment IV

ACKNOWLEDGMENT OF GRIEVANCE

TO: Inmate Felty, David ADC# 95976 UnitMaximum Security

FROM: Max J. Mobley, Deputy Director

RE: Receipt of Grievance MX05-1339

DATE: October 10, 2005

Please be advised, the appeal of your grievance dated 9/2/05
was received in my office on this date 10/7/05

You will receive a response from this office by 11/17/05

OR

☐ This grievance is being returned to you because the time allowed for appeal has expired

☐ This grievance is being returned to you because you have not attached
- ☐ the informal resolution (Attachment 1)
- ☐ the original grievance form (Attachment 1a)
- ☐ the Warden's/Center Supervisor's Decision (Attachment 2)
- ☐ the Infirmary Response and/or the Mental Health Response
- ☐ a clear statement of appeal (Back of Attachment 2)

Return your grievance with the checked items if you wish to continue the appeal process.

Exhibit # C1

Back of Attachment II

INMATE NAME Felty, David ADC 95976 GRIEVANCE MX05-1339

DEPUTY/ASSISTANT DIRECTOR'S DECISION

Your appeal dated September 10, 2005 states that you have not had x-rays taken of your patella and that the two occlusion x-rays have not been returned to your medical file from Dr. Burnett's office.

The medical staff states that you reviewed your complete medical file on August 30, 2005 with the exception to the two x-rays, which you state, were not found in your medical file. It is noted that they were located in Dr. Burnett's office. You filed your appeal two days after the medical response was generated which did not allow staff time to retrieve and place them in your record.

You have been advised that if you are having difficulty with your knee then you need to submit a sick call to be evaluated with possible referral to see the physician. Any x-rays must be at the recommendation of the unit provider, not the nursing staff.

This appeal has no merit.

SIGNATURE of MAX MOBLEY

10-25-05
DATE

Please be advised that if you appeal this decision to the U. S. District Court a copy of this Deputy/Assistant Director must be attached to any petition or complaint or the Court must dismiss your case without notice. You shall also be subject to paying filing fees pursuant to the Prison Litigation Act of 1995.

Felty, David
ADC: 095976
BRKS: 7-07

We received your request for interview:

Date received: May 1, 2006

Your request for interview concerns your medical jacket and some missing information and two occlusal films. We have researched you medical jacket and found the following information.

Jacket volume II contains: Progress notes from 1996, 1997, 1998, 1999, 2000 and 2001. It contains the refusal for surgery for the stone under your tongue from 2000 and a treatment sheet for weekly blood pressure from 2001. It also contains chronic care notes from 2001.

Jacket Volume III contains: Your transfer in 2001 and your approval to work in food service in 2001. This volume also contains surgery consent form from 1997. It includes notes from the orthopedics in 1996, and many progress notes from 1999 through 2001. This volume is where I found the progress notes from your knee surgery in 1996.

Jacket Volume IV contains: sick calls from 2000 and 2001.

I spoke with the doctors office that has your occlusal x-rays that office is sending them to us. They state they will put them in the mail today. If I can be of further assistance please let me know.

J. Stell LPN
Grievance Nurse
MSU
May 18, 2006

Received: 5/19/06 Responded with below: 5/22/06

I still need 1991 – 1996, this is the material ive not been able to review because it is not a part of my files upon review.

I Assume it would be volume I, seeing you have volumes II, III and IV.

12-29-402. Physical examination — Assignment to labor.

(a) All prisoners committed to the Department of Correction shall be given a physical examination initially upon arrival and then as often as determined by medical staff of the department.

(b) Inmates shall be assigned to labor as shall be fitting, with due consideration being given to their physical condition.

History. Acts 1943, No. 157, § 3; 1981, No. 59, § 2; A.S.A. 1947, § 46-138.

12-29-403. Disabled convicts — Duty of physician.

(a) (1) In the case of any convict claiming to be unable to labor by reason of sickness, it shall be the duty of the physician to examine the convict.

(2) (A) If in the opinion of the physician the convict is unable to labor, the physician shall immediately certify his or her opinion to the Director of the Department of Correction.

(B) The convict shall then be relieved from labor and sent to his or her cell or admitted to the hospital or elsewhere for medical treatment, as the physician may direct, with due regard being given to the safekeeping of the convict.

(b) The convict shall not be required to labor so long as the disability continues.

(c) Whenever the physician shall certify that the convict has recovered, he shall be returned to labor and not before.

History. Acts 1893, No. 76, § 34, p. 121; C. & M. Dig., § 9665; Pope's Dig., § 12705; A.S.A. 1947, § 46-151.